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ABSTRACT

The effect of changing patterns of postsecondary education for nursing and the subsequent development of open curricula and external degree programs in nursing are examined in these conference papers. The following papers were presented: "Pressures on Higher Education Are Changing Post-Secondary Education," by Robert H. Kroepsch; "The Open Curriculum in Nursing," by Lucille E. Notter; "Schools Proposing Open Curriculums Have Expectations of Boards of Nursing," by Verle Waters; "Expectations of Boards of Nursing When Schools Propose Open Curriculums," by Rose P. McKay; "Evaluating Open Curriculum Programs," by Kathryn A. Hecht; "A Panel: The Regents External Degree Program," by Donald J. Nolan; "The New York Regents External Degree: Opportunity for Non-traditional Students in Nursing," by Carrie B. Lenburg; and "Registration of the External Degree Program in Nursing," by Eileen A. McQuaid. (SW)

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BOARDS OF NURSING — OPEN CURRICULUMS

Papers Presented at the ANA Conference
For Members and Professional Employees
Of State Boards of Nursing
And Members of the ANA Advisory Council
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INTRODUCTION

The effect of changing patterns of post-secondary education for nursing, with the subsequent development of open curriculums and external degree programs in nursing, is an issue of vital concern to the profession. On June 7, 1974, at the Hotel St. Francis in San Francisco, members and professional employees of the State Boards of Nursing and members of the ANA Advisory Council met to hear and discuss information presented by eight persons involved in these new approaches to education for nursing.

ANA President Rosamond Gabrielson brought greetings to the assembly. Presiding at the morning session was Marguerite Hastings, R.N., New Hampshire, Chairperson, Council of State Boards of Nursing. Merlyn M. Maillian, R.N., Louisiana, Vice-chairperson of the Council, presided over the afternoon session. Moderator for the panel presentation of the New York State Board of Regents External Degree Program in Nursing was Mildred S. Schmidt, Ed.D., R.N., Executive Secretary, New York State Board of Nursing.

Pressures on Higher Education Are Changing Post-Secondary Institutions

By Robert H. Kroepsch, Ed.D., LL.D., Executive Director, Western Interstate Commission For Higher Education

Perhaps you are one of those who has seen that mind-boggling film *2001—A Space Odyssey*. If so, you will remember the hero traveled in a space ship at the speed of 100,000 miles an hour to the farthest edge of the solar system, through the Star-Gate, and into the space that men call "real." To many who saw this film it was eerie, disturbing and "far out." However, we must remember that science fiction more often than not has provided us with a vision and a prediction of what is to come. And 2001 is only 27 years away!

Those who will enter college this fall from high school will be in their mid-forties in 2001. Those graduating this year will be in their early fifties. And those of you who are now 50 will be 77. Thus, many in this audience will actually witness the birth of the 21st century.

What will it be like? How can we prepare for it? How can we keep up with the dramatic changes that will occur in the meantime in our own country and in the larger world community? In short, how can we avoid future shock?

Might it help to look back 27 years ago at how we were then? Perhaps. What was it really like in those good old days?

In 1947 the freshman class in American colleges numbered approximately 600,000. This fall it was almost 2.3 million, nearly a four-fold increase. In 1974 the number of college degrees awarded was four times what it was in 1947. In the late forties it wasn't streaking that made campus news, it was panty raids on women's dormitories. Coed dormitories would not appear for another 20 years.

In 1947 no man-made object had yet orbited the earth, and it would be 10 years before the Russians launched Sputnik. Since then we have put men on the moon. An abandoned sky lab now circles overhead and will continue to do so for at least the next few years.

In 1947 polio was a dreaded and crippling disease against which the country mounted a massive campaign. Today it is under control.

In the early forties it was the sulpha drugs on which we pinned our hopes for success in our battle against disease. It was several years before penicillin was to be found in the doctor's kit. The Pill had not yet emerged from the laboratories. Today its use has resulted in many dramatic social changes in our society and in our life style.

In 1947 abortion was a word not even used in polite conversation; now it is commonplace in all the media.

Segregation was the law in many states. The war on poverty had not begun. Affirmative action was not even conceived. Computers were not in common use. Today they seem to touch, and even control, most aspects of our everyday life.

Perhaps what is most important is that in 1947 students were preparing themselves to work in an industrial society. Today students are also preparing themselves for an industrial society. But the economists and futurists believe that they will undoubtedly live most of their lives in what is being called the Post-Industrial Age—an age in which large numbers of people will be trained and will be concerned primarily with the production and marketing of ideas and knowledge instead of being involved with the production and marketing of things.

I can no more tell you what this new age will be like than could a late 17th Century scholar have described the effects of the approaching industrial revolution, but I can tell you that I am certain the world will be very different in the 21st century, and that each student graduating this year will have to make many and frequent adjustments to factors and conditions as yet unknown.

And all this is happening already. Change is occurring at a rapid rate, an ever-increasing rate. And this change is fueled by the explosion of knowledge and technology. It is this explosion and its effect on the rate of change, and on our institutions and the health system, on which I would like to focus.

But to understand the impact of the knowledge explosion we must look back to the Italian city states at the end of the Dark Ages. In the sudden flowering of knowledge and inquiry that characterized that period, the Renaissance man was born.

This man was marked by the scope of his knowledge, his curiosity, skills and talents. He attempted to master all the known literature in the field of the arts, humanities, and sciences. But he was more than a learner, he was also a doer. Not only did he excel in poetry, music, philosophy, and painting but also in architecture, physics, astronomy, anatomy, and engineering. Such a man was Leonardo da Vinci. He was the outstanding genius of his age, and he set goals for other learned men.

As an educational goal, the concept of the Renaissance man has attracted generations of students and has set the traditional standards for our colleges and universities.

Today, we mourn the passing of the Renaissance man. The ideal he created lasted for a long time because for more than 400 years the total body of Western knowledge remained at a limited and manageable level. Until recently the expansion of knowledge occurred at only a gradual rate. Few fields were marked by rapid change. And because of this, graduates of colleges and universities could pass through all their working years knowing that their educational background and technical knowledge would stand them in good stead. The family doctor who practiced 50 years ago is a prime example.

The possibility of becoming a Renaissance man ended with the knowledge explosion that began with World War I.

True, there are a few men and women around, like C.P. Snow, Buckminster Fuller and Margaret Mead,

who some might think approach this ideal, but they are rare—perhaps the last of the species.

While we welcome the knowledge explosion because it means a better life for most of us, we also must recognize its impact on higher education, on today's graduate, and on all of us here.

As a result of this explosion, we are all forced to specialize. Not only is the generalist disappearing from the educated world, but so also are the men and women who can even manage to keep a full grasp of their own major field. Throughout the entire university, each specialized discipline has altered the traditional concept of the educated man.

To be an intellectual today often carries only the meaning that one has mastered his own field. The shadow of the Renaissance man no longer falls across the campus. His heritage of intellectual breadth and wisdom is no longer a realistic goal of students or of institutions.

With this prologue as a backdrop, I'd like to share with you now some of my own personal views about education and health. I must, however, insert a strong disclaimer. These are my personal views, and they do not in any way purport to reflect the views of the 39 different WICHE Commissioners or even of the WICHE staff, even though I suspect that many of them might agree with much of what I shall say.

What will the health system of the future be like?

Several years ago former President Nixon stated, "No American will be prevented from obtaining basic medical care by inability to pay." Although this goal is still somewhere in the future, the implications of this statement are shared by the leaders of both political parties, and each one of them made his pitch at the National Governors' Conference in Seattle earlier this week.

I believe such a goal will eventually be reached, but before it can, there must be drastic changes in our health system, in its structure and its organization, in the way it is operated and financed, in the people who manage and deliver services, and in the educational systems that not only prepare people to deliver health services, but help to prepare people who receive those services.

Here are some of the characteristics of our future health system as I see it.

It will be comprehensive. A full range of care and services will be available to everybody—health maintenance, disease diagnosis, acute and intensive care, and restorative and extended care. The system will embrace mental illness, as well as alcoholism and drug abuse. Health education will reach all of the people and increasingly people will receive health care, especially at the maintenance and prevention level, where they live, where they work, and where they go to school

There will be a new and increased emphasis on health maintenance and disease prevention. People responsible for the system, as well as the public, will finally recognize that the prevention of illness is a less expensive undertaking than the treatment of acute or chronic disease. New scientific developments and preventive medicine will contribute to this trend.

The health system will be based on national systems, and I use the plural here not knowing what we are going to end up with, of health insurance. There lie ahead bloody and painful battles among politicians—they have already begun—insurance companies, labor unions, taxpayers' groups, and organized medicine; but eventually there will emerge equitable systems for all, and even the middle-class will not be forgotten.

The system will have a greater capacity for change than our present one. Computers will give us the ability to test out the implications of various management decisions quickly, as well as the ability to determine the unit costs of various procedures accurately. Scientific knowledge will continue to develop rapidly and be applied more quickly and broadly. Communications networks will provide for the rapid exchange of information among health professionals at all levels, expanding each one's scope of vision, and incentives will be established to encourage the demonstration and evaluation of new methods and means of providing health care. And consumers and taxpayers will demand both excellence and efficiency.

The roles and tasks of health professionals will be far less rigidly defined than they are today. Health care teams will obscure the existing sharp lines between health professionals. In different situations, different members of the team will be the leaders and decision-makers. New health occupations will emerge; others will change; and some may disappear.

For example, a cure of cancer will release many highly specialized health professionals to concentrate on other problems. Licensing and certifying agencies face many headaches, but they will adjust, and state lines as barriers to practice will disappear.

Continuing education for all members of the health systems will be necessary to keep pace with rapid change, and increasingly, universities will recognize continuing education as one of their major functions, rather than as an add-on or overload function.

Consumers of health services will play a significant role in planning, policy-making, and evaluation of the health systems. Their voices will be heard loud and clear, not only as individuals, but through advisory committees and councils at the community level, as well as at the state and national levels.

And how will this health system be staffed?

Most health care will be provided, not by individual practitioners, but by health teams. They will be organized to provide efficient and thorough health care by utilizing the talents of each member of the team to the fullest extent, thus freeing those with unique talents from tasks which can be performed by others.

And there will be a variety of health teams. Let me describe at least four.

Environmental Teams. These will identify unhealthy elements in the physical and social environment and work to correct them. The geographical area on which they will focus could be very large—an entire river system, for example.

Health Maintenance and Disease Prevention Teams. These will operate in a more limited community, supporting the work of the environmental teams and providing health education and comprehensive screening for disease.

Acute and Intensive Care Teams. These will function primarily within the walls of medical facilities, which will include many new types, providing optimum care for seriously ill patients.

Restorative and Extended Care Teams. These will render care, including therapeutic and psychological services, to patients recovering from various degrees of illness.

To date, most of our past efforts have been focused primarily on the functions performed by the acute and intensive care teams. In the future, more resources, including time, money, and research, will be funneled into the activities of the other three teams.

An increasing number of interested and able volunteer workers will assist in the actual delivery of health care, serving as essential members of every type of health team. And as their competencies improve, they will even assume some duties which are now thought can only be performed by professionals, and I think licensing boards will assist in this development.

One of the great educational challenges will be to prepare all those who will manage the various segments of the health system—people skilled in management who must also have a working knowledge of the entire system and a basic understanding of the concepts of health and illness.

There will be health ombudsmen. They will serve as consumer advocates, helping people to make full use of the health maintenance system, facilitating their entrance into the acute or restorative systems, and assisting them to cope with those systems successfully.

Managers of health-related enterprises, who may not be members of traditional health professions, will be broadly educated and knowledgeable and will administer health programs at the national, regional, state, and local levels.

A new breed of health facility administrators will be needed to manage new facilities for health maintenance and restorative care as well as acute care centers.

Planning and management specialists will design and operate the management information systems which will be essential to support highly complex health structures.

Health data specialists will bridge the gap between the data management professionals and the health professions. They will conduct research on consumer characteristics, history, and needs, and will disseminate these data quickly to appropriate persons in the health systems.

The primary generators of change will be researchers and evaluators:

Biological and environmental researchers who will uncover new knowledge to improve the efficiency of all elements of the system.

Technical researchers who will invent and perfect new medical machines and technological devices.

Clinical care researchers who will develop research to determine which approaches, activities, or techniques used in the direct care of patients will result in optimum patient response and recovery, and nurses will undertake increasing responsibility for this and other types of research.

Health care delivery researchers who will subject the various systems of delivery of health care to intensive research and evaluate the results of different approaches.

Management researchers who will continue to search for new techniques for efficient management and optimum cost effectiveness.

Evaluation specialists who will provide feedback loops serving all operations, and consumers will also play an active role in the evaluation process.

The health system itself will embrace an educational component which will have at least two major functions. It will assume increasing responsibilities for staff training and staff development in close cooperation with educational institutions. There will be regular procedures for re-examination and re-certification as prerequisites to continuing practice.

There will also be educators of consumers. When people are acutely ill, it usually takes but a little education to convince them that they should seek medical help. It requires a far more sophisticated educational program to convince people who are well that they should take precise and aggressive continuing steps to maintain their health. A substantial cadre of personnel, specially trained, will perform this function.

And so, what are the implications for educating health professionals for the future?

Margaret Mead's classic quote has special significance for health education. She says, "We must educate people in what nobody knew yesterday, and prepare people in our schools for what no one knows yet, but what some people must know tomorrow." I say this quotation has special significance for us here today because it is estimated that within a few years health care will represent the largest segment of employment in this country.

For example, in 1972 the enrollments of college juniors in health professional programs increased more than in any other field; a whopping 19.5 per cent over 1971. In second place were the life sciences with a 12.8 per cent increase and in third place social science majors with an 8.3 per cent; and all this happened in one year, during which the total size of the college junior class increased only 3.2 per cent.

It has been pointed out by Alvin Toffler that in order to avoid future shock, our entire educational system must shift its focus from the past and present and devote more of its attention to the future. We must produce personnel who will coordinate and deliver health care in new ways, personnel who are not afraid of innovation and experimentation, and personnel who do not fear sound methods of evaluation.

The mix of people who educate health workers will change. In addition to the traditional types, there will be specialists in ecology and pollution control. Social and behavioral scientists will orient students to human perceptions, needs and problems. There will be experts in communications, and management experts, and systems analysts. And members of minority and ethnic groups will sensitize all health workers to the very special needs and to the value systems of nonwhite, nonmiddle-class cultures. And increasingly, we will use health practioners in tandem with professional educators.

Consumers and volunteers will be trained as educators to teach the elements of health maintenance in their home communities. Selected residents of rural communities will serve as health maintenance educators. Influential persons in ethnic communities where distrust and language barriers now prevail will provide health education for their own people. Many more students will

work part-time during vacation periods as health educators for selected communities.

And faculty members will change, too. They will become people-oriented and teach their students about health care for people rather than about patient care only. Webster's dictionary defines "patient" as "one who suffers or endures; as in a hospital." This concept is too limited. Although there will still be patients, the education of all health workers will be focused on the broader concept of health care for all people.

Faculty members who gain leadership roles will earn them because of their talent, creativity, interest in change, orientation to the future, and interest in people. Seniority and formal credentials will be less important. Department chairmen and deans who are resistant to change and who refuse to embrace it, or who represent the autocratic or authoritarian patterns of the past, will not be re-appointed, but will be replaced.

Ways and means will be devised to make individual faculty members aware of the importance of keeping the content of what they teach relevant to the real world. Each faculty member regularly will have practical experience as a health worker outside the walls of the institution in which he teaches, preferably in a situation that is novel. This will be a requirement for continued employment.

White faculty will be sensitized to the problems, needs, and value systems of the nonwhite population, and efforts to promote racial understanding will be made in every educational setting. In addition, white faculty will have practical experience in working outside the institution in various types of community settings.

There will also be changes in the categories of people who are educated. More opportunities to become leaders in the health professions will be provided to members of minority groups. Schools which prepare people for professions now dominated by women will actively recruit more men, and schools which prepare people for professions now dominated by men will actively recruit more women. More health education will be given to such people as community planning administrators, welfare workers, social security administrators, providers of health insurance, managers of health facilities, and analysts of health care systems. Community people who want to serve as volunteers on various types of health care teams will also enroll for instruction.

For every person who is part of the health care delivery system, there will be a requirement for continuing education programs. And institutions will decentralize continuing education facilities to minimize the travel required of health workers. The budgets of schools preparing health professionals will reflect this new emphasis on continuing education.

Because of the rapidity with which new knowledge about all aspects of health care will be discovered, curricular revision will be continuous. Curricula will focus on techniques of health maintenance and disease prevention, but more emphasis will be given on psychological concepts, an overview of the health systems, techniques of scientific management and systems analysis, relationships between health care and the law, and the development of new health career programs.

Team teaching will increase and will reflect an interdisciplinary approach to education. Different types of health professionals will be educated together. There will be developed mutual respect among specialists in all health and health-related disciplines. The acceptance of the team concept in the classroom will support teamwork later in the field. If they are to work together, they must be taught together. There will be maximum utilization of community resources. There will be maximum utilization of technological teaching devices. Flexibility in the educational time span will be introduced so that students can more easily progress at their own pace. Current internships and residency programs will undergo drastic changes.

After a core program of health education, most health workers will choose one of two primary career patterns. One track will emphasize practice that is essentially curative and restorative, as in institutional settings. The other will emphasize practice in community settings, largely outside hospital walls, concentrating on health maintenance and disease prevention.

All means of promoting and rewarding career development will be utilized. Credit by examination will be universally accepted. Tested competencies will qualify students for credit. The concept of the external degree will be accepted in theory and practice. Highly motivated and mature students who pass examinations will be awarded the appropriate degree regardless of the time they have spent within the walls of educational institutions. The opportunity to exercise options at various points on any health career continuum will be provided and encouraged, and new career ladders with built-in crossovers will become commonplace. All this will require better and more effective counseling of students.

To provide every student with the connecting link between his or her education and role as a health worker, educational facilities will be increasingly decentralized and associated with the new facilities for the delivery of the health care. Ambulatory clinics, outpatient facilities, extended care units, half-way houses, nursing homes, and neighborhood health centers will be used as educational laboratories in the preparation of all types of health workers. A major part of each student's education will be provided in new types of educational settings, such as neighborhood and small town health centers, and in more centralized special service facilities which will back up the network of the smaller centers

Shifts in attitude on the part of both consumers and health workers will provide a powerful force for change in the health systems and the process of educating for it. Evaluation by students will increase. They will serve in significant numbers on faculty committees that make recomendations about student life and about their preparation as health workers. There will be regular evaluation of teaching by students, by peers, and by outside consultants to judge each faculty member's effectiveness. This will be an important component in making decisions about promotions and salary increments.

Most schools will retain outside and impartial evaluators to survey the products of the system; that is, their own graduates, at a reasonable time beyond graduation, to ascertain the graduates' attitudes toward the quality and relevance of their education. Those who employ the products of the system will also evaluate the quality and scope of the health workers' learning.

There will be more emphasis on research in the

delivery of health care in various types of settings, as well as the cost effectiveness of various approaches. There will be research on teaching techniques and much more experimentation with innovative approaches. More experiments involving control groups will be mounted.

And every institution of health education will establish and maintain the equivalent of a Council of the Future in the sense proposed by Alvin Toffler in his book *Future Shock*. These councils, consisting of students, faculty, practitioners, and consumers, will brainstorm freely, even wildly, about the future, making predictions, drawing up plans, and initiating change. They will draw on all the sources of research and thinking, and feed their conclusions back to all components of the system. They will have the authority to implement experimental programs based on their predictions, thus helping their institutions, as Toffler puts it, to "invent the future."

In closing, I quote again from *Future Shock*. "The inability to speak with precision and certainty about the future, however, is no excuse for silence."

I have tried to encourage all of us who have any responsibility for the delivery of health care or for the education of health professionals to shuck off the old myths, attitudes, and stereotypes that inhibit us and to embrace innovation, change, experimentation, and evaluation, so that in the 21st century toward which we are rushing at a rapid rate, the health needs of our people will be more fully met.

What I have proposed may seem indigestible to some of you. Others will say that the obstacles are too formidable to overcome. However, almost everything I have described exists and is working well somewhere. What we need to do now is to find ways to put it all together, knowing full well that we cannot design the ultimate; we can only continue to struggle towards it.

The Open Curriculum in Nursing

By Dr. Lucille E. Notter, R.N., Ed.D., Division of Research, National League for Nursing

In a paper given at the National League for Nursing's recent open curriculum conference, the second in a series of four that have been planned, John Valentine, who is the executive secretary of the Commission on Non-Traditional Study, said, "The idea of a learning society is a goal toward which this country is moving and must move if it is to survive and flourish."

He further reported that, "Members of the Commission on Non-Traditional Study used the phrase 'learning society' repeatedly in their discussions of the implications and thrust of non-traditional study. According to them a learning society encompassed many avenues and methods of learning and not just those labeled formal educational opportunities."

Sam Gould, who was chairman of the Commission on Non-Traditional Study, considered non-traditional study more an attitude than a system of education in his report of the commission's work entitled "Diversity By Design." He concluded that this attitude puts the student first and the institution second, concentrates more on the former's need than the latter's convenience, encourages diversity of individual opportunity rather than uniform prescription, and de-emphasizes time, space, and even course requirements in favor of competence and, where applicable, performance.

This attitude is not new. It is simply more prevalent than it used to be.

No one here would argue against his statement that nurses comprise a large and important segment of our society and that they are a part of the movement toward a learning society.

The emphasis on higher education and on continuing education for nurses is compelling evidence of nursing's thrust toward making learning a continuing life-long activity of nurses.

The movement toward open curriculum and career mobility is but one aspect of this movement in nursing. Career mobility is not new in nursing or in this country for that matter. It has been a part of our democratic tradition. Even advanced placement and credentials for such placement by examination are not new. Many of us old timers in our pursuit of higher education have experienced it.

I am one of those people who came out of a diploma program, and I certainly went through a lot of some of these kinds of experiences myself. I know many others, perhaps some in this room, did, too. However, the present educational movement toward totally flexible individual program planning which recognizes the value of prior education, however achieved, is a recent phenomenon.

In its most radical form this philosophy is expressed in the "university without walls," or the "external degree program," which grants credit by transfer or examination for relevant knowledge gained through traditional or non-traditional sources.

In nursing I would say that career mobility or the open curriculum is a phenomenon of the last 10 years with growing intensity during the past four or five years.

Most of the 51 programs that are part of the NLN open curriculum project initiated their current open curriculum practices during the period from 1970 to the present time. We had some earlier, but the large majority of them are new.

The open curriculum practice project at the League came about because of the interest of the League in the growing movement in nursing education to provide programs which met the needs of nurses for higher education without the frustrations of encountering repetitious course content and which recognized professional knowledge and skills already gained.

The immediate stimulus for initiating the open curriculum project was the policy statement on the open curriculum in nursing education approved by the NLN Board of Directors in February, 1970. I am sure all of you are familiar with this statement. It was published in the July, '70 issue of **Nursing Outlook**.

It was a bold step. It defined open curriculum and career mobility and outlined the NLN beliefs about these two concepts.

I would like to take time out just to read it to you, because I think it will set the stage for this.

> An open curriculum in nursing education is a system which takes into account the different purposes of the various types of programs, but recognizes common areas of achievement. Such a system permits student mobility in the light of ability, changing career goals, and changing aspirations. It also requires clear delineation of the achievement expectations of nursing programs, from practical nursing through graduate education. It recognizes the possibility of mobility from other health-related fields. It is an inter-related system of achievement in nursing education with open doors rather than quantitative serial steps.
>
> The National League for Nursing believes that individuals who wish to change career goals should have the opportunity to do so. Educational opportunities should be provided for those who are interested in upward mobility without lowering standards. In any type of nursing program opportunity should be provided to validate previous education and experience. Sound educational plans must be developed to avoid unsound projects and programs. More effective guidance is urgently needed at all stages of student development. If projects and endeavors in this area are to be successful, nursing must accept the above concept of the open curriculum.

One of the first steps in the implementation of this statement was the appointment of an advisory committee for the study of the open curriculum in nursing.

The purpose of NLN open curriculum project is to influence the open curriculum movement in nursing in two ways—through study and through action.

The study aspect of the project began with a survey of

the movement in nursing education. All types of basic nurse preparatory programs were included—practical or vocational programs, diploma programs, associate and baccalaureate degree programs, and baccalaureate programs for registered nurses only were also included when known.

The survey consisted of a short questionnaire sent out in October, 1970, with the usual annual survey. As a result of responses to this brief questionnaire which indicated wide reception to the open curriculum concept and acceptance of limited open curriculum practices, the advisory committee for the study of open curriculum in nursing, at their meeting in February, 1971, recommended the following:

1. Collection of information pertaining to existing techniques for granting credit and advanced placement.
2. Development of new instruments for granting credit and advanced placement.
3. Study of current experiments and demonstrations which have open curriculum elements and issuance of guidelines for schools interested in establishing open curriculum practices.

Funds were sought and obtained in 1971 from the Exxon Education Foundation to begin the project, and in January, 1972, a second survey was carried out.

The results of this survey are published in the April, '74 issue of **Nursing Outlook**, in an article by Lenburg and Johnson.

At that time the data indicated that baccalaureate programs probably are more willing to grant advanced placement to those who have both education and licensure as registered nurses, while diploma and associate degree programs are more amenable to advanced placement for non-graduates of registered nurse programs.

The data also showed that 33 percent of the programs admitted students with previous education and/or experience without examination; however, credit or advanced placement may or may not have been given.

In addition, another 60 percent admitted students with some form of examination procedure for advanced standing. Approximately 6,300 students with previous educational experience were enrolled in baccalaureate programs and over 3,800 in associate degree programs. Advanced placement problems which hindered shortening of programs were identified at that time as rigid course sequence requirements and lack of appropriate and reliable examinations.

Teacher-made tests were most commonly used. College level examination programs, the CLEP test, were the second most commonly used tests for non-nursing subjects; whereas, NLN tests or a combination of NLN and teacher-made tests were the second most commonly used for nursing subjects.

In the spring of 1973, the *Directory of Career Mobility Opportunities in Nursing Education* was published by NLN. The directory, the first of its kind, was based on two 1972 surveys—the one done in January that I mentioned, and the one done at the time of the regular fall survey of schools. It lists almost 15 open curriculum programs. It provides information about types of programs, kinds of students admitted, methods used for advanced placement, and maximum time or effort which the student can save in the program.

These programs discussed in the directory can be classified generally under four distinct curriculum patterns.

Type 1 includes programs that accept only licensed personnel.

Type 2 includes programs that provide advanced placement opportunities usually through testing procedures.

Type 3 includes programs that allow multiple exit options.

Type 4 includes programs that award degrees on the basis of examination alone without required attendance or course sequences and that, of course, refers to the external degree programs.

Some schools combine aspects of several of these patterns.

And now I would like to backtrack a bit. At their meeting in March, 1972, the overall advisory committee reconsidered the situation in the light of what appeared to be happening in nursing education. They recommended starting an action program. They believed that the development of models of open curriculum programs in these several schools would be the most helpful thing to do at this time and point, and they set up a task force to work on this.

The task force met throughout that year. Then as a result of their review of the data coming in by the NLN surveys, (particularly the January, 1972, and the fall, 1972, annual survey, the ones resulting in the directory) the task force, better known as the Project Planning Committee, changed its mind and decided that the development of models was no longer appropriate. Too much was already happening, and it appeared more appropriate to select models of programs already in existence and to study their development and progress as examples and for use in developing guidelines for the assistance of schools interested in developing new program.

As you can see, we are still concerned about this development of guidelines.

In the fall of 1972 the Project Planning Committee developed criteria for the selection of pilot programs to participate in the project and invited schools of nursing to indicate their interest in participating in the action study project which would involve their meeting together, sharing information, and eventually collecting data for the purpose of developing the proposed guidelines for the sound development of open curriculum projects and of solving some of the difficult evaluation problems envisioned.

Approximately 200 schools responded. Using the material submitted by them, together with site visits to a selected number of the schools, a total of 51 schools, 27 individual programs and 5 consortia were involved and were selected on the basis of criteria established by the Planning Committee.

These criteria included items relating to administrative support and procedures, policies of the state regulatory agencies, faculty preparation and philosophy, flexibility of the curriculum and the philosophy and theoretical framework which guided the curriculum as well as use of the innovative teaching strategies, the policies governing student admissions and advanced placement as well as assessment of progress and the use of the standards of competence based on stated objectives and ade-

quacy of resources and finally, evidence of plans for periodic evaluation of the program.

I have summarized these rather briefly. They had rather extensive descriptions at the time.

The 51 institutions selected represented various sections of the country, various types of programs according to the four patterns that I mentioned and various levels of educational preparatory programs.

By this time additional funding had been received from the Educational Foundation of America to extend the Exxon Education Foundation funding.

Two meetings of the 51 project schools have been held. The first open curriculum conference was held in St. Louis in the fall of 1973. Prior to this session each school was asked to submit an abstract describing the program, the various open curriculum practices in effect, and the various problems faced. These were collated and sent to each of the participants prior to the conferences.

Programs among the schools differed considerably. Some were in the initial planning stages, some still are; others were in all stages of development, including a few relatively well-established programs involved in developing or carrying out research on teaching strategies and/or advanced placement examinations.

A variety of interesting teaching strategies were reported, including self-pacing, individualized, independent study modules, audio-visual materials, all sorts of multi-media, and innovative methods of providing clinical experiences. Programs ranged from those accepting aides and corpsmen into licensed practical nurse or associate degree programs with advanced placement to those providing advanced placement in traditional baccalaureate programs and those providing advanced placement into upper division two-year baccalaureate programs in nursing.

A few were moving toward a two-plus-two program in nursing with a core curriculum in the earlier years preparing for the A.D. option at the end of two years or four quarters or the option to go on and complete the baccalaureate.

Multiple exit and re-entry options were common to a number of the programs. One consortium includes an imaginative articulation among eight schools and provides advancement from aide through graduate work. One of the two schools in the consortium providing advanced placement toward a baccalaureate degree will include an experimental two-year upper division program. This consortium will also include one school providing a graduate program at the master's and doctoral level.

Major problems reported in the abstracts by the schools included recruitment of faculty, development of testing programs, particularly in clinical areas and in performance evaluation, and difficulties posed by regulatory agencies.

There were other problems that included measuring change in role attitudes of students, and methods of changing attitudes of faculty toward non-traditional teaching strategies. According to some schools the latter requires considerable in-service education, and the general support of the program by their administration. Some have obtained funds for the development and evaluation of the open curriculum projects and some of these schools have well-developed plans for the study of their students and the followup of their graduates.

For example, one school has planned to use pre- and post-attitudinal questionnaires to determine changes in concepts regarding professional nursing and health care.

There is some question as to whether a person's concepts can be changed from, say, practical nursing to professional nursing or A.D. nursing to professional nursing. This school will include in its program a followup study of the graduates as to how they are using their additional education in practice.

This school also plans to do a profile analysis of each student who enters the open curriculum program and compare him on the longitudinal basis with their baccalaureate students and the same instruments will be used on both the traditional and non-traditional baccalaureate students and other schools are still in the planning stages as far as overall program evaluation is concerned.

The first open curriculum conference was devoted primarily to an exchange of ideas with each school elaborating on research on the abstract report included or submitted and successes as well as problems were exchanged. There seemed to be a genuine feeling of progress being made on the frontier of great importance to nursing.

The prevailing atmosphere was one of sincere desire to participate in the development of sound practices and many commented on the relation of their programs to community needs and the pressures from society to do something to free opportunities for educational advancement in nursing.

This is also evident from data obtained in another survery done by the NLN Research Department which they are currently analyzing.

We have a new study going on which I think corroborates some of this material. As a result of the surveys in the current open curriculum project the researchers developed a hunch that there were a number of registered nurses obtaining their baccalaureate degrees in schools without basic nursing programs. To test this hunch a survey was made of about 1,200 colleges and universities which were not known to NLN as having a basic baccalaureate nursing program.

The purpose of the survey was to identify four-year schools that have nursing programs for registered nurses only and who have registered nurses enrolled in fields other than nursing. In addition, it was hoped to determine numbers of registered nurses enrolled in the various programs.

You may be interested to know some of the tentative findings; 33 schools reported that they have had a baccalaureate program with upper division nursing for registered nurses only, and 24 additional schools reported that they are starting up or planning a baccalaureate in nursing for registered nurses. Approximately 200 schools have registered nurses enrolled in baccalaureate programs without nursing content. These nurses are usually majoring in other fields such as psychology, sociology, or biology. Some of these schools have enrollments of between four and five hundred students.

I might say we had about a 70 percent return on this questionnaire which indicates approximately 70 institutions stated that they had nurses in their schools but did not keep separate statistics on them, so could not give data on the numbers enrolled.

Some of these institutions that were surveyed also mentioned the pressure of communities, pressure to

develop a nursing program.

Analysis of the data from this survey is still in progress and figures I have given you are preliminary ones, but they do indicate what may happen when there is no community plan to meet the higher education needs in nursing or the plan in effect requires what the nurses consider to be uneconomic of time and effort and not attuned to their needs.

Some of the figures from this may be reported later in the publication which the League will have out, including some statistics of baccalaureate and higher degree programs in nursing.

The second open curriculum conference was held last month with the same study project representatives attending it.

Again we were indebted to the Exxon Education Foundation and the Educational Foundation of America for funds they had previously granted to the project.

The last conference focused on the framework or external constraints in which open curriculum projects are developed. It was recognized that the movement toward non-traditional curriculums in nursing were operating within the framework of the larger movement in higher education.

While no predictions for the distant future were made, one might easily visualize changes in education as a result of changing teaching strategies and curriculum practices that will be as great as the changes that occurred when the first book was written, and the printing press was first used and audio-visual aids first came into use and instant television of world events became common.

At the first conference problems and barriers were identified which were based on constraints posed by regulatory agencies; therefore, other frameworks within which the new programs must operate, which were discussed at the second conference, included the university or institutional setting, the State Education Department, the State Board of Nursing and accreditation.

The focus was on planning sound practices and working closely with the regulating agencies involved.

Open curriculum programs that are not built on sound educational principles will defeat their purpose of increasing the educational opportunities for nurses and improving the quality of nursing care and health care services.

The third conference in this series is coming up this fall. It will focus on assessment procedures, both cognitive and clinical for advanced placement and for assessment of progress.

Overall program evaluation will also be examined. Experimentation and the development of nursing assessment tools and evaluation models is one of our critical needs and a major goal of the NLN project will be to stimulate this experimentation and the development of more adequate tools.

By fall, 1974, when the third conference is held, it is hoped that we will have the framework established for the collection of data by the schools that will help to further evaluate the movement. In addition to general statistics about enrollment we hope to be able to compare data on a role, enrollment, attrition, and the product of the various types of open curriculum programs with data from the more traditional programs.

It would be of interest to know whether students graduating from open curriculum programs with self-pacing independent nursing practices, where the focus is on the student and what is good for him and not on what is good for the teachers or the institution, will continue the practice of self-learning as graduates and whether they are more likely to go on for graduate education than perhaps the more traditional student; this kind of information would depend upon longitudinal studies. But if we are educating nurses to live in a learning society, these traits are important ones to nurture.

If our goal is, as we say, to educate independent practitioners, then is non-traditional education the route to take? Many think it is. Stephan Bailey described in a paper given at the first annual conference on non-traditional studies held in November, 1973, three stages of progress in the development of new and changing programs. He was speaking primarily of the external degree program at the time. The three states were:

1. Euphoria—the commitment of discovery of a beautiful new way to approach education which focuses on the student.

2. Despair—when all of the obstacles and problems are met or imagined.

3. Sober Optimisms—when some of the problems are solved and progress which is always slow begins to make all the hard work worthwhile.

And now while on the subject of sober optimism, I would like to close on a warning note; while the open curriculum or non-traditional movement in education and in nursing education may in the long run be another and in some cases a more effective way of improving the quality of education and the product of our programs, no one has ever said that it was an easy method.

Some may have thought it was. I am sure many faculty have found working with students on self-pacing or independent study programs to be harder than providing a group of students with a lecture, but to paraphrase a popular book of a few years ago, perhaps they shouldn't expect a rose garden.

However, it looks as if the new method is here to stay.

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Schools Proposing Open Curriculums Have Expectations of Boards of Nursing

By Verle Waters, R.N., M.A., Curriculum Coordinator, Cooperative Graduate Education in Nursing Consortium

In the opening of curriculums in nursing we see practices which are not only non-traditional, but practices which, from a traditional point of reference, would be labeled academically unsound.

For years higher education has tried to fit students into programs. Now suddenly we are fitting programs to students, and educational enterprises are tumbling about in unaccustomed places, with unlikely learners doing unheard of things.

As non-traditional approaches proliferate, the sense of concern about how to measure quality increases. As one's reliable standards are challenged, we tend to rely more on those still enforceable.

It is tempting to settle ambiguity by acting with certainty.

I, along with many, have been watching with alarm the curriculum decisions being made which are based on the theoretical framework of a California legislator.

My interest in boards and open curriculums has grown as I worked as consultant to a number of schools where open curriculum approaches are being planned or implemented.

Within the past two years I have worked with faculties engaged in open curriculum undertakings in eight states and I share that with you only so that you know my frame of reference.

By nature, boards and the laws which they implement do not spark innovation.

Therefore, let me address the subject of the relationship in nursing between statutory authority and the curriculum of the school of nursing.

My remarks derive from my belief that the open curriculum movement in nursing creates a situation which makes it timely to examine that relationship. The past relates to the present and may guide us in selecting a course for the future.

The Council of State Boards is certainly a fighting group in which to undertake this examination, for some of the most action-oriented forebearers in nursing were crusaders in the state registration movement in the early years of this century. One was Sophia Palmer, editor of the **American Journal of Nursing** and many years president of the New York Board of Nurse Examiners. She was sharp of mind, tongue and pen. She knew the importance of state registration for improving standards in nursing and worked at it hard.

For more than two decades the **American Journal of Nursing** gave a dominant place in its pages to state legislation, and the administration of the Nurse Practice Acts. Miss Palmer addressed the New York Federation of Women's Clubs in 1898 and she, Miss Dock, Miss Hampton, and others apparently sought many opportunities to address women's clubs as often as they could, seeking their support in the areas for improving nurses and nursing.

What nurses wanted, Sophia Palmer explained to the group, was the right to regulate admission to their ranks. The members of the examining board which passed on the qualifications of nurses must be chosen not by political influence, but from among nurses themselves, and the New York Federation of Women's Clubs became actively engaged and helped promote the passage of a law in New York State which created the official post of nursing inspector of training schools. Other states followed Miss Palmer's suggestion, appointing training school inspectors as one of the official acts of the board.

The general acceptance of that idea as told by historian Mary Roberts caused the boards to place primary emphasis on the upgrading of schools rather than on the practice of individuals, as was the case with other professions.

Certainly nursing schools at the time needed all the help they could be forced to take. And it was an obvious point of attack. Schools were in hospitals and no standard-setting agency reviewed or approved the course of study, faculty qualifications nor adequacy of clinical experience, and further, Roberts points out the state boards lacked the facilities for investigating individual violations of the law.

Nonetheless the precedent was established, the statutory authority in nursing was to be directed toward control of educational programs more than practice.

At first upgrading the school required detailed descriptive curriculum specifications to protect students and assure them of balanced experience which would prepare them for the world of the registered nurse of the day.

An early provision specified that all learning take place in the hospital. This was to prevent the assignment of students to home cases where the hospital collected the fees charged to the patient. In time that stipulation became an obstacle as faculties later sought to balance a program with out-of-hospital experience and then that provision had to be changed.

Over the period we have learned that a statutory standard specifying curriculum content, sequence, length of study, etc., creates more problems than it solves, and the language and approach to the R.N. curriculum in all states is now, I believe, adequate to the criteria of balance, yet general enough to permit flexibility and freedom.

Many of the programs that are working with the open curriculums are having difficulty with the standards for vocational or practical nurse licensure in their states because the inflexibility and quantitative curriculum re-

quirements in those laws have made it impossible to develop some of the curriculum overlaps that are seen as desirable. So, we have spelled into our law the ingredients of an approved course of study as a condition of accreditation. Thus, it is quite possible and perfectly legal for postscriptive or prescriptive political intervention to substantively shape the curriculum.

Briefly, let me cite as an example the California legislative activity. I want to make clear this is not a report on the California legislative scene. I'm not at all prepared to do that. I want to draw some examples for the purpose of making a few points.

With strong external and internal forces impelling toward the opening of curriculums, it may be that an earlier response from nursing educators in California could have precluded the aggressive legislative structuring for open curriculum. I do not know but I think the question is academic.

Under energetic legislative leadership over a five-year period a highly prescriptive curriculum structure has been outlined in various ways for our schools in this state. Assemblyman Gordon Duffy, an optometrist, has actively introduced a number of legislative proposals at intervals which, if all were to be enacted, would make changes along the following lines in our curriculums:

1. All hospital-based nursing schools would be required to establish affiliation with a college which would allow all graduates to earn a degree.

2. All schools would be required to develop a course of study which would enable students to qualify for the vocational nurse licensing exam in the first 18 months of the program.

In 1971, a bill was introduced which would have required programs to qualify students for the vocational nursing exam at the end of the first year of the program.

3. In another provision, all schools would be required to develop a course of study which would enable students to qualify for the registered nurse licensing exam in the first three academic years of the program.

In 1971, a bill was introduced which would have made that provision required at the end of the first two years of a program.

4. The Board of Nursing would establish the necessary hours of instruction and hours of clinical experience necessary to qualify for the registered nurse licensing exam. That provision, if it were enacted, would remove the present requirement that in order to qualify for the state licensing exam you must have earned the degree associated with the program that you were in. This would determine that the board would spell out the hours of instruction and once you had achieved those, you would be eligible for the state licensing exam.

5. The Board of Nursing would establish uniform equivalency examinations for all the various courses given in nursing schools. An applicant for licensure would be credited by the board for as many as seven courses by successfully passing the equivalency exam for these courses. Some of these are inactive provisions and some of them are active. They have all been proposed at one time or another.

These five provisions have many implications and would create severe consequences were they to become law. It is ironic that these proposals are an expression of a desire to open up nursing education. In comparision with prevailing trends in higher education today these provisions make the 1937 curriculum guide for its time look absolutely liberated.

The result would indeed be a nursing education system more restrictive than the one it is said it will supplant. At a time when the cry is for more options, such provisions would eliminate options. Mr. Duffy's program raised the question of the relationship between nursing curriculum standards and statutory control.

In specifying not only that an educational program must be approved, but spelling out the criteria for quality and assigning accreditation responsibilities to the board, we make accessible the curriculum design, content, method, and style. Our vulnerability now derives from the precedent of selecting the upgrading of schools as the prime point of leverage. By no means do I suggest that the boards have not upgraded schools or that they are not now upgrading schools. They have and continue to do so. The question being raised is this: "Is the approval of the educational program, based on statutory criteria the best avenue for boards to pursue in carrying out their charge of protecting the citizens of the state from harm at the hands of unqualified practitioners?"

Nursing has long selected standard setting for education rather than practice as the focus of our quest for potency. The hope that through the education of the neophyte we might improve practice runs long and deep in our history. The American Nurses' Association's first position paper was a declaration of intention with regard to nursing education rather than a declaration of competent nursing practice.

Persistently we tried to solve the problems of the work world by doing something to the education program. We note the fragmentation of patient care and reinforce the curriculum with comprehensive patient care and continuity of care concepts. We view with dismay the inadequacies and inaccuracies the care patients receive and resolve to create change agents in our curriculums. The setting is the powerful determiner of practice, and practice cries out because management, accountability, and responsibility have become new bywords in nursing education and no other words could be closer to the charge of the Board of Nursing in the state. These words relate to practice and accountability in the care of patients.

A second question: "Is the picture in nursing now changed or changing so that we might plan for the assigning of the approval of schools to other agents of control in our profession?" Requiring, of course, that licensed applicants be graduates of such accredited programs, but the criteria for accreditation being resident in other agents in the occupation.

This is June and students are graduating from nursing schools in all the states. Two-thirds of them are graduating from schools operated by colleges and universities. Of these half are accredited by the National League for Nursing. All of them are subject to regional accrediting bodies and for many there is also a state agency committee or board which reviews and approves curriculums, to say nothing of organizations like Western Interstate Commission for Higher Education, Southern Regional Education Board, and the New England Regional Board, which are involved in the up-

grading of schools. From the days when hospital nursing schools were unchecked by any regulation beyond that of their own consciences, we have come to a time when the nursing school chairperson may be submitting curriculum plans for approval to four standard-setting agencies. It is no longer the world Sophia Palmer and her energetic colleagues took on.

Is it time for re-evaluation of priorities? I believe we should think on it.

I close with two lines quoted by Bernice Anderson: "New occasions bring new duties, Time makes ancient good uncouth."

Expectations of Boards of Nursing When Schools Propose Open Curriculums

By Rose P. McKay, Ed.D., Colorado Board of Nursing

The widespread quackery, commercial exploitation and deception in medicine and law during the 18th century was the reason many of the then existing states passed licensing laws, and by the 1900's medical licensure had included specific requirements relating to scientific education and character as part of the licensing statutes.

In nursing in 1896 the forerunner of the ANA began to be concerned about licensure and by 1903, Virginia and New York had laws; by 1920 all 47 of the states had laws for nursing. New York was the first to appoint a training school investigator and the emphasis definitely was on the schools rather than on the practice of nursing. I think we may be coming to the end of that era.

I can not believe that the emphasis on practice can continue to be de-emphasized by the Boards of Nursing. Until just a few years ago issues such as licensing, certification and accreditation were generally thought to be the concern of the professional individuals and organizations that were affected by them.

Then came the American Medical Association and American Hospital Association recommendations for institutional licensure and the moratorium on the licensure of new health professions.

When you look into the history of nursing, you find that only 47 states have licensure. Some states have permissive, but most of them have mandatory licensure.

Some texts indicated that the pressure for open curriculum came from the R.N.'s who wanted to move ahead.

To me, as a member of the State Board and as a nursing educator, the pressures for open curriculum in nursing came not only from the R.N.'s but also from the proponents of institutional licensure citing nursing as the example of the inflexible profession where everything had to be repeated.

The delivery system in health care is at a point where it is trite to say that it is a non-system. The nursing education system in many ways resembles that same situation.

The public policy aspects in relation to licensure very often have been perceived by legislators and other bureaucratic decision makers as inflexible, as in opposition to openness and flexibility. I think that this is the proposition we are encountering when we go to our bureaucratic boards. They perceive any attempts to regulate licensure, to regulate schools as more evidence of inflexibility and the public sector is becoming so concerned with licensure and accreditation now that we are encountering many new resistances.

In the last 25 years the number of professions, skilled trades and even semi-skilled jobs contingent upon a satisfactory demonstration of competence and integrity before a governmental licensing body has doubled. That is why we have a moratorium.

As has been noted, licensing statutes which established standards of professional performance were originally intended to protect the public from dishonest and incompetent practitioners. It has been observed that "every profession strives to persuade the community to sanction its authority within certain spheres by conferring upon the profession a series of powers and privileges." These powers and privileges include professional control over academic and training institutions through accreditation, entry into the profession by requiring graduation from an accredited professional school, and legal ability of the individual to practice by means of state licensure.

Two basic requirements for this licensure are a duly granted professional degree obtained by completing an accredited program of formal education and an examination by the peer group, such as nursing's State Board Test Pool Examination.

There are other ways besides the one we have used for granting accreditation to schools. We examine the applicant's credentials, the term of education and experience, and moral fitness—some state boards do still estimate moral fitness.

Investigating the schools to determine if a program meets required standards is accomplished by other professions in several ways. The state board can accredit itself. A national accreditation standard can be accepted. Many of the allied health professions do that. Approval by the State Department of Education is also accepted. Approval by a regional accrediting agency such as the North Central or something like that is also acceptable. We have the tradition of inspecting, but really what we are committed to is guaranteeing that the program adequately prepares practitioners. We could easily accept guarantees other than personal or site visits.

Most state boards are composed of representatives of the groups with direct interest in the area regulated by the board. If you have all nurses on the board, the appointments are not supposed to be political. Believe me, that is not so. It can be a very political thing. There are recommendations from the State Nurses' Associations, but are they always adhered to? To what extent do the recommendations from the State Nurses' Associations have influence on the governor who appoints the board?

If nurses want to be on the board, they have to be politically active. Some of the best qualified nurses simply don't have the time.

How many state licensing laws require educators to be on the board? How many of them specify what kind of educators should be on the board?

Now, the boards vary in size, but most of them have about 10 people. The composition of the boards will certainly influence what the boards can expect of the schools. If there are educators on the boards, if there are no individuals experienced in innovative curriculum developments, how will the boards go about assessing these developments?

We have a very heterogeneous system, a non-system

you might say. Thinking about the system theory one might ask whether or not the system is an open system or a closed system. According to the definition of these systems, one that is closed is characterized by increasing disorganization; that is, every component of the system is like every other component of the system. That isn't our system, is it? Can you think of any instance when any components of nursing and education or practice are like any other component? We are very individualistic. We can conclude that we have an open system.

This is a period of extreme social change. So, what happens to the system during that period? You develop increasing complexity and a lot of separation. Many specialists develop who only know their sub-specialty. There are a few generalists. You don't have the Renaissance man; you have sub-specialties.

The other thing that happens during a period of rapid growth, especially when you can't forecast the input elements, is that there is no plan to handle the growth. That is what is happening now. Because input is so variable, there is a tremendous emphasis on control mechanisms and I don't think there is any more beautiful example of control mechanism than rules and regulations of state boards of nursing.

Rules and regulations are control mechanisms, and in periods of change there tends to be an emphasis on control mechanisms. That is not good, because the system has to be open, it has to be flexible, it has to be moving, and if we emphasize control mechanisms, we are going to lose the richness and diversity that has been characteristic of nursing in its adaptability to changing social pressures.

Another problem that I note in my experience in state boards is that the regulatory agencies of the state may disagree. In Colorado, for example, the State Board of Nursing supported open curriculum, the State Board of Occupational Education did not, and the Colorado Commission on Higher Education ignored the whole issue.

There are many agencies to which schools report and they may be in disagreement. It is trying and very difficult for the schools.

I think the state boards should make every effort to get together with the other state regulatory agencies and at least communicate or try to communicate.

One of the things I learned is that state boards in nursing are boards that make decisions. In some of the other boards, the staff makes decisions. I am speaking from my experience as a member of a very responsible group. Our board meets often and we delve into problems. We feel responsible and try to make decisions, but some of the issues that are coming to our board are becoming increasingly complex. I don't know if we can continue to cope with all the issues coming to us.

Last year I would have said there is no doubt we must get involved with approving, inspecting and accrediting and doing whatever it is we do about two-plus-two programs. When we were writing our new state law in Colorado, the section about accreditation is phrased in such ambiguous terms that we could possibly include continuing education and two-plus-two programs.

I am willing to say I don't know if we need to get involved in the two-plus-two programs. That is another complexity. We are going to have enough of a job to get to do the programs that are preparing for licensure.

I don't know of any school in the state of Colorado that isn't involved with some aspects of open curriculum. When you talk about the open curriculum we are not just talking about just the League study, you are talking about every thinking faculty member.

You are going to get increasing numbers of open-curriculum schools. Lucille Notter mentioned the R.N. pressure for an even greater movement from the L.P.N. to A.D. Because there are more of those schools and because faculties are smaller, they move faster. I think we are going to get an increasing number of applications from A.D.N. programs.

How many people on the board are really prepared to make the kinds of decisions that these new innovative programs demand? Do they meet standards? Do they fulfill our rules and regulations interpreted very flexibly and supported in an open system way? I tried to list some things the state board should think about. I defined conceptual framework evident in the organizational sequence of the nursing content. How do you place task analysis and test analysis approach when test analysis isn't a conceptual framework and how do you define a conceptual framework for A.D.N. programs? Suppose you had a multi-exam of the open curriculum. What is the conceptual framework of the A.D.N. program? And you have to go through the whole thing for aide and L.P.N. and R.N. and then two-plus-two programs. Then you have to go through it again. How do you make decisions about things like that? Faculties working on these matters are not going to come out with the answers immediately.

If there is an open door policy, what self-pacing program is used? Describe the planned use of non-clinical laboratories. Innovative teaching methods and equal emphasis on the content in both years of the A.D. program is needed unless we are willing to admit that the L.P.N. is more than halfway to being an R.N. We have seen some programs—L.P.N., A.D.—where all the nursing content is in the first year and that is what used to be done.

I came up with some things that I felt were more specific for the board. Affirmative action plans and what we call "recycle." "Recycle" means an open curriculum with multiple kinds of entry and exit, having affirmative action plans where self-pacing students have an opportunity to go back and try again without being punished for failure.

Can we adopt that attitude toward the state board test pool? If the students pass it eventually, is that what counts, or do we still have to have a standard that a school is no good unless all the students pass the first time? You see? We really have to think about these things in terms of the open curriculum and the kinds of attitude values, teaching strategies, and methods that the faculty in these programs are developing.

I had a list of considerations for the baccalaureate program, too, but I am running out of time. However, faced with this variety and complexity in the traditional program, one is faced with the question, "Can the state board still be responsible for the assessment of experimental and innovative programs which the open curriculum movement represents?" Where will the expertise come from to make the decisions? I wouldn't

want to get to the point of not having the state board responsible for saying which programs are approved and which graduates come from an approved program, but surely there must be someone who can come up with an alternative that each board has to do the investigation itself.

I think I have commented on the members of the board and their expertise in regard to evaluating all these complex situations. It isn't fair to expect the state board consultants to make all the decisions about approval, where all of the research projects over a ten-year period in the country are unable to answer that challenge.

In a book written in 1923 by Chartus named *Curriculum Construction*, the author urged job analysis as the basis for curriculum development. He condemned systematically organized knowledge because it changes constantly, application may not be easy, motivation is often lacking, materials may be correct but not useful.

How many of you have taught first-year students? Do you ever get any of those responses? Chartus suggested what he called a functional approach;—analyze the job, analyze the science appropriate to the job to be taught, find out what is being done and then do it. Start with easy and progress to difficult; emphasize areas where error might occur. This is functional and it is related to the task analysis approach which is so frequently talked about when you discuss open curriculum versus flexible curriculum with occupationally-oriented people. They determine task analysis as: (1) defining each task, (2) indicating the skill involved, (3) stating the purpose of the task, and (4) describing the knowledge required to perform the task.

Even though it is recognized that job analysis in a service rather than a production industry is still rather undeveloped, you will see and hear a lot about this approach especially in the occupationally-oriented school—the community colleges.

How to build an assessment and approval of accreditation program is difficult. It will have to move from the task analysis of a baccalaureate program from the nursing theory model of the integrated curricula to the medical model. Thus, at a different level, a task analysis approach to practitioner programs is a rather overwhelming task for the state boards and their state board consultants to face, especially in this era of budget shortages and increasing emphasis on the supervision of the practice rather than education.

I would not recommend giving up responsibility to insist on standards for schools to achieve, but the development of these standards for experimental programs seems to be beyond a reasonable expectation for state boards to achieve within the next few months. I think the board should take the position to encourage sound trials of innovative programs, to encourage cooperation among the schools, and in the states that are trying out these ideas.

The open curriculum study is only the surface that shows of the changes that are going on all over the country. The problem of limitation to programs preparing for licensure is another. I can defend that both ways: A flexible attitude is needed toward interpreting rules and regulations, and consideration of other forms of recognition of adequate programs for the future is a must.

It seems to me that these are criteria where the state boards should be in relation to the open curriculum. Florence Nightingale once said, "The purpose of nursing was to give comfort, not in the present rocking chair sense of comfort, but in the traditional Latin meaning—to stand strongly together." I think that is what we have to do. We must support flexibility, openness, and standards in nursing with the experimentation that is going on in relation to the open curriculum.

Evaluating Open Curriculum Programs

By Kathryn Hecht, Ed.D., University of Alaska

What is evaluation and how is it defined? Evaluators and nurses have something in common. We are both in helping professions, though yours is considerably older than mine. There is no one accepted definition of evaluation, as we are speaking of a field that is relatively young, relatively unknown and unused until about ten years ago. Evaluation, more specifically program evaluation as I speak of it, can be defined as the process of providing useful information for decision making.

The process includes the delineating of information needs, the obtaining of data and organizing it into useful information for program improvement.

Evaluation is both quantitative and qualitative, and should not be limited to test scores or testimonial statements. Useful evaluation of an educational program will make use of whatever reliable information is relative to planning, developing, maintaining, and improving a program.

While making judgments about decision alternatives is central to the definition I described, the act of judging is usually not considered the evaluator's role. Again, the evaluation process supplies information to the decision makers.

How does program evaluation differ from research? It is the usefulness criteria which evaluation strives to meet which differentiates it from more basic research which seeks to discover new and generalizable knowledge applicable in every situation. Information derived in evaluation is more limited, in that it applies primarily to the situation or program which it serves. In other words, in research, the research hypothesis dictates the design of the project. In evaluation, the evaluation is a service to a specific program and is tailored to the the program's needs and may be adjusted should those information needs change.

However, the distinction is not quite so black and white. Evaluation may be thought of as being on the applied end of a research continuum with basic research on the opposite end and a gray or mixed area in the middle.

Why does one evaluate? For what purpose? One which has already been implied is for program improvement as a tool of management. Two, one has an obligation to one's profession to share the latest developments and not operate in isolation. Three, one has an obligation to the public in most types of education. Evaluation for all of these purposes must concern itself with both program description and effectiveness, though not necessarily to the same degree.

How does one evaluate? What does the methodology tell us? Speaking generally, there is no one evaluation model which is totally sufficient, nor applicable in every situation.

In my previous paper on evaluation and open curriculum, I described several well-known models. Each offers insight which could be helpful in evaluation planning, though some mixture of models and multiple measures are used in actual evaluation practice. Currently evaluation seriously suffers from a lack of an intergrated comprehensive theory or methodology. The success of any evaluator seems based as much on political astuteness, human relations, logic, and pure intuition as technical skills.

Generally, program evaluation is most useful or successful when all those involved in planning, implementing, and judging a program understand and have a say in developing evaluation plans. Evaluation is not and should not be a sole preserve for those who are considered or who have appointed themselves experts.

As noted earlier on getting to plans for evaluation, the delineation of what information will be considered useful or what are the questions to be answered is central to planning and evaluation, and should be decided upon in conjunction with those managing a project. Evaluation plans must, therefore, be developed with a knowledge of what is being evaluated, why, and by whom.

The section in my earlier paper entitled "Evaluation Considerations" posed more questions to those involved and concerned with open curriculum study than provided answers. I considered this suitable, as the open curriculum study itself and the direction it is taking is in its formative stages. Any evaluator who says he or she has the answers and doesn't plague the program developer with constant questions should be regarded with a great deal of suspicion.

Seriously, perhaps the most difficult task in evaluation planning is to decide on the priority questions and the information needs. It is, therefore, not too early to consider evaluation as part of planning for open curriculum, so as to avoid a common pitfall of loss of information that plagues late or post-hoc evaluation attempts.

Leaving the more general discussion of the evaluation, what considerations are most pertinent to the open curriculum study? Last year I raised numerous issues and questions which I will now review to be followed by a discussion of progress during the past year.

In evaluating pilot projects, the NLN was cautioned to recognize, prepare themselves, and educate others to the fact that these projects have not yet proven to be successful, regardless of how innovative they may appear and that as much can be learned from those which fail in whole or in part as from those which succeed. Not that anyone wishes that there be failures, but not to consider or be prepared for the possibility could allow significant loss of valuable information through oversight or concealment. A lack of openness could seriously jeopardize the value of the study as a learning experience for the profession as a whole. A climate of trust during this trial period is essential.

It should also be emphasized throughout the study of the pilot projects that they are not representative of all schools of nursing, all open curriculum programs, nor even those volunteering to be in the study. These projects can be spoken of as being chosen as the best or most useful for the purposes of study. This is a perfectly sound rationale as long as it is made explicit and generalizations to larger universes are not attempted.

Some questions I raised in the paper last year included the following: What is to be evaluated? According to the NLN, both the pilot projects and the universe of 1,600 open curriculum projects were identified in the earlier surveys. Some of both can be done now in that there is considerable descriptive information available from the survey and pilot study questionnaires and additional information from the onsite visits. It was suggested that survey data should be compiled and analyzed for what it offers.

What does the universe of 1,600 open curriculum projects look like? What do the selected 32 pilot projects look like?

What is the NLN's role in open curriculum? If it is promoting an awareness of open curriculum in an objective fashion, evaluation could be heavily descriptive eventually leading to the development of guidelines. This was the direction it appeared to be taking.

Another perspective would be to ask what areas of NLN services are likely to need to be changed in some way as a result of open curriculum, such as testing and accrediting, and should be included in planning?

However, not all information need be developed centrally. Decisions concerning individual pilot projects are made at local levels. To insure quality of project decisions, should the NLN require review of evaluation plans and provide evaluation training as payoff for participating in this study?

At all stages both NLN and pilot projects themselves will probably want information as to open curriculum effects on students, faculty, employers, and on the school itself.

Questions raised may include: What conditions favor open curriculum development? In what context does it occur? Who thinks it is important? Is it pushed more by students, administrators, etc.? Who sponsors the program? What resources are utilized—What is the input? What are the major design trends and how are they developed? What types of students are attracted? What is the level of demand? Are the designs implemented as planned? How is the program carried out? What is the process and how well is it working? What changes are being made during the program? What are the outcomes or products? What is the graduate failure attrition rate? Are students entering the nursing profession without prejudice? What is the overall performance, academic and on the job? What are the relative costs?

Many of these questions could be asked in comparison with the nonopen curriculum population. NLN might consider developing data collection instruments for joint NLN-local use which would not only encourage local evaluation and provide a service, but also insure uniform data collection at the national study level.

It was pointed out that decisions as to what are priority questions and information needs, and at what level they can best or most practically be answered, are needed before evaluation planning could rationally proceed.

It was suggested this process could begin by reviewing an analysis of the data already collected. Another relatively simple approach would be to collect pilot project objectives plus variously related overall objectives plus those that NLN staff might suggest.

Once the focus of evaluation was more clearly in mind, a major hurdle would be development of standard criteria. How does one know if a program is reaching its objectives? The NLN is in a favorable position here to prescribe measuring instruments likely to be its own or ones developed to meet open curriculum needs.

The difficulty in developing criteria is related to the four programs leading to the practice of nursing and a curriculum that is currently in a state of flux. For this criterion problem there seemed to be two major tie-ins within the NLN itself. The NLN's Division of Test Construction was at this time last year carrying out a study on the issue of what is being taught in each of the three R.N. routes—how it was the same and how it differed. The survey was to look at behavioral objectives for patient care in all four nursing programs.

The second tie-in, which seemed obvious to me at least, was a question of expected performance and performance criteria for graduate nurses being raised in conjunction with the State Board test pool examination validation study.

In concluding my paper for last year, I stated that if open curriculum were to flourish, it would seem that tests more standardized than those commonly made up locally would be required both to assist programs in assessing individual student progress and to evaluate the program itself.

In updating my comments from last year my data sources for doing so were limited to written information obtained from the NLN which did not include information from most recent months or any material directly related to NLN evaluation plans and actions.

During the past year, the NLN has begun to clarify its role in the study of open curriculum, as was well described to you this morning, in terms of 1.) study and 2.) action.

In relation to the first or study goal, descriptive information from earlier NLN surveys on open curriculum has begun to be analyzed and some already publicly reported as in the Lenburg and Johnson article.[1] Certainly, this is a beginning. To achieve the study goal as described by the NLN, which includes "to ascertain if practices are achieving objectives . . .," it would appear that more surveys will be needed.

However, statistical survey data are not an end in themselves and certainly not sufficient to perform the evaluation that the study goal indicates. One must know, first, what those objectives are; then how they are to be judged, and then collect the appropriate data to answer the questions thus generated. The analysis of objectives suggested last year still seems appropriate, beginning with the pilot project ready at hand.

Are other surveys planned? Since a survey cannot be of infinite length, priority information needs should be identified first. How could these data information needs mesh into other information already collected or contemplated at NLN for other study or research use?

Turning to the second or action goal, the fact that two conferences for pilot schools have already been held speaks to its implementation.

I recently reviewed the abstracts and summary of problems and barriers from the first open curriculum

[1] Lenburg, C. and Johnson, W. "Career Mobility in Nursing: A Report of the NLN's Open Curriculum Project," *Nursing Outlook*, first proof, March 1974.

conference, November, 1973. Some of the expected problems did surface and should be further considered in evaluation planning as possible barriers to program effectiveness and/or areas where information would be needed for immediate decisions or more long-range guidelines.

For example, the criterion question of expected performance was addressed from several angles. Specification for expected behavioral outcomes or competencies were requested by the pilot schools for various levels of nursing, including job analysis, to delineate functions and accompanying performance measurements.

Related to open curriculum, it was further noted that researchers showed it difficult to distinguish between levels of practice, but that the very concept of levels of nursing is the basis for open curriculum. It also noted that competencies, if they were to be developed for various levels and be realistic, should seek agreement from both education and service.

From another point of view conference participants also considered it necessary to identify the common basic skills and to revise the State Board exams to more closely reflect current curriculum patterns.

Other problems mentioned in several contexts were a variety of sources of resistance to the new programs, especially from faculty and the state boards. In some cases, even student attitudes were considered an important variable as a source of resistance. A great deal of this was attributed to lack of understanding which dissemination should begin to alleviate, but which evaluation should not neglect, especially the importance of studying attitude changes.

Another area mentioned by pilot projects under both needs for assistance and problems were tools for evaluation: the need for individual student assessment—measurement, diagnosis, and achievement—and especially the need for measurement of clinical performance.

Program evaluation studies which were called for included comparative studies of the open curriculum versus traditional programs and studies of cost effectiveness. Other specific requests were for evaluation help and included: Wanting to share evaluation and measurement plans among the pilot programs; wanting to know what tests were available; and wanting guidance on what kind of data should be collected—faculty, student, funding, curriculum, entry behaviors, and institutional context. Again questions of prioritizing data needs and availability of suitable measures came to bear. Through reviewing the abstracts of the pilot programs prepared for the first conference some educated guesses could be made concerning their evaluation planning activities. The evaluation plans in these abstracts varied considerably in both their specificity and sophistication of approach.

A few looked comprehensive and of high quality, as they considered students, faculty, facilities, and curriculum in their plans; used multiple measures to evaluate both competencies and attitudes; incorporated evaluation into planning, on-going, and followup stages, and cited specific evaluation models.

However, such comprehensive approaches were rare as judged by the abstracts. Some looked only to assessment in future times, while others were solely concerned with current needs. Some looked only to student achievement measures or even success on licensure exams. Some felt no different or special procedures were needed for the pilot project. Several noted that their programs were still being planned or that the programs were too new to evaluate. Several mentioned evaluation taking place only at the end of the program or course. Staff time allocated to evaluation also varied, from a full-time staff member to no one given the specific responsibility.

I am concerned that often evaluation plans appeared far more limited than the variety of problems that were identified in the abstracts. Another concern is the lack of recognition noted in many of the abstracts of the need to begin evaluation as early as possible and to continue it throughout the project and the followup period. This review of the pilot project evaluation plans would suggest need for assistance and training from the NLN in evaluation.

This tentative finding has already been confirmed by the problems and needs for assistance identified by the projects themselves at their first conference, as discussed above.

Recent developments overall seemed to indicate the NLN and Open Curriculum Pilot Project Planning Committee's early concern for evaluation was well-founded. This was expected. The early interest of the pilot project in evaluative-type questions and problems was probably not as anticipated and should encourage the staff and the committee to play a vital leadership role in evaluation planning and training.

In conclusion, it appears that evaluation is an integral function to the study of open curriculum. Realistically, I recognize and should point out to you, in looking back at this paper and considering the information I have just recently received, that the NLN lacked the funds for comprehensive evaluation study envisioned at the time I first became involved. However, many of the evaluative suggestions I have made to you today could be and should be integrated into other nursing activities and studies, though economy was not my initial concern.

Open curriculum is not an isolated movement within nursing education and practice. It raises basic questions and issues concerning the effectiveness of the current system. Evaluation planning should be no less comprehensive, if these questions are to be answered, if the pressures to change and to resist that change are to be meaningfully balanced to the betterment of the nursing profession.

A Panel:
The Regents External Degree Program

By Donald J. Nolan, Ph.D., Coordinator of Academic Programs in Higher Education, New York State Education Department; Director, Regents External Degree Program

The Regents of the University of the State of New York are offering undergraduate degrees to anyone who can meet the requirements with or without attending college.

With grants from Carnegie, Ford, and the Kellogg Foundations, plus a very successful and extensive credit by examination program, the regents have been able to award degrees on their own behalf for the first time in their 190 year history.

In fact, in the last two years the regents have conferred 1,225 associate in arts degrees to graduates who range in age from 19 to 74 and who come from all of the states of the Union except Vermont.

These graduates have earned credit toward their degrees by taking regular college courses. They have taken course work from such organizations as the United States Armed Forces Institute; they have passed college equivalency exams like New York's College Proficiency Examinations as well as the CLEP exams, the college level program of the College Board, while others have had their military service experience evaluated.

Among the graduates we already have are housewives, teacher aids, policemen, military personnel, some nurses, secretaries, businessmen, and even college students, which was surprising to many of the faculty.

Some of the graduates never attended college. They used the proficiency exam and military evaluation route, but the vast majority, 83 per cent, used college courses in combination with proficiency exams in order to earn their degrees.

It really is a program that cooperates and coordinates with the existing educational institutions across the country.

One of the difficulties in talking about external degrees is that we are not always talking about the same thing. "External degree" is probably the most elusive term to define. Let me tell you what we think it is, and you can use your own judgment in terms of what it is on your campuses.

You may recall that in the 19th century the University of London gained a certain amount of notoriety for an external degree. In fact, for the first 70 years or so the University of London had nothing but a faculty based in London and students from all over the world studying at home. There were no students on campus, but the University of London degree carried no "external" label.

In the early 1900's the University added residential or internal students. They still only give one degree, the University of London degree, and a student is either external or internal in terms of the transcript.

In the way that we use the term in the University of the State of New York, an external degree is one which is awarded by a university which evaluates a student it has not taught. That is the basic distinction. In the past few years, perhaps spurred on by the British Open University, there have been many off-campus or extended campus programs announced in the United States.

Some of the best known include the University Without Walls, a group of about 25 colleges working under the Union for Experimenting Colleges and Universities, the California State University and Colleges consortium, and Minnesota Metropolitan State College. In New York, Empire State College is a college without walls which uses the 71 campuses of the state university as its springboard and its resources and teachers known as mentors or learning facilitators.

The whole idea in all of these programs is that there is a faculty member who teaches the students or at the very least guides them through the learning process.

What sets the regents' external degree apart is that the very nature of the University of the State of New York is quite different. This "university" has no campus, no students, no faculty, and no buildings, at least not in the common understanding of those words; but by law, since 1784 when the legislature enacted the bill, the University of the State of New York, referred to as USNY, comprises all of the educational resources we are using. The external degree is awarded by the University of the State of New York.

The University of the State of New York is the system of education in New York, and consists of all 230 of the state's private and public colleges, the elementary and secondary schools, museums, libraries, historical societies. It is presided over by a Board of Regents, 15 lay men and women elected by the Legislature for seven year terms. USNY's executive officer is the state's commissioner of education who is appointed by the regents. The commissioner also serves as president of the University of the State of New York.

The regents and the commissioner are responsible for all of education, and for licensing most professions except law. The regents also supervise and monitor all of the academic programs in the state, and they are empowered to confer degrees.

Until recently the regents had not conferred these degrees on their own behalf, but instead had limited their activities to honorary doctorates and degrees of the private colleges during the provisional chartership of those colleges.

Because of their considerable experience in this field, the regents have been recognized by the United States Commissioner of Education as an accrediting body in their own right, along with the six regional associations, for the general accreditation of colleges and universities.

About 1960 the regents announced their decision to offer credit by examination through the College Proficiency Examination Program and from 1963 to the present, the regents have administered more than 50,000 examinations and can document credit awarded by the colleges far exceeding that amount.

The most popular College Proficiency Examinations (CPEs) are in the nursing sciences. There are also CPEs in the arts and sciences, teacher education subjects, and in business. The CPE program is a state-funded pro-

gram of the State Education Department, the administrative arm of the regents.

When the exams have been taken and the grades determined, the department then recommends to the colleges and to the Regents' External Degree faculty a certain amount of credit. It is up to the individual colleges and to the external degree faculty either to accept or reject that recommendation.

The College Proficiency Examinations, however, do not satisfy the nursing requirements in the Regents' External Degree Program. The external degree faculty in nursing voted to develop their own examinations along the lines of an integrated curriculum. The CPEs in nursing cover single subjects along traditional lines.

The Regents' External Degree Program builds on the experiences of the proficiency exam, especially in its use of the faculty and maintenance of high standards, and it is not a state-funded program. The Regents' External Degree Program has been funded principally through outside grants from the foundations that I mentioned and through student fees.

Right now there are the following degree programs available in the Regents' External Degree Program: associate in arts, which has 1,225 graduates already; associate in science; associate in applied science in nursing; bachelor of science in business administration; bachelor of arts, and bachelor of science. The last two will be approved by the regents this month, and will be made available, assuming their approval, in the first part of July.

Each degree program is different, but there are some common elements that run through all of the programs. For example, there are no admissions requirements. The candidates may reside outside New York or within it. There is no age limit. The method of preparation is not prescribed. The general education requirements can be satisfied by passing courses at accredited colleges. Eighty-three percent of the graduates have taken some college courses. There is no classroom attendance required, however. Seventeen percent of the people who earned the degree did it without attending a formal collegiate institution.

At present there are more than 6,000 people enrolled in the programs with one-half the students enrolled in the associate in arts programs, the remaining half evenly divided between the nursing program and the bachelor of science in business administration. Actually, nursing is slightly ahead of business and has been enrolling people for one year less time. So, you can get an idea of what the growth picture is like.

We have been conducting followup studies on the graduates as part of our attempt not only to evaluate the program but also to do some research that will help us in future programs. We have learned that the principal candidate right now for the the A.A. degree is on active duty in the military: nearly 800, or more than 60 percent of those seeking the A.A. They range in age from 19 to 74, with an average age of 33. Fifty-four percent of the graduates in the first study we did are now in their junior or senior years in 88 different colleges in 32 different states across the country.

I am not sure that these colleges have accepted such a large percentage of our graduates because of us. I am convinced that these colleges need students, and, with an average age of 33 and the backgrounds that most of these people bring with them to a college, they really are good bets to do well in the junior and senior year. For these reasons, many of our graduates are getting preference when they apply.

Many of the other graduates are using their degrees to meet job requirements. This is especially true in the all-volunteer army.

The college faculty and administrators constitute a committee for each degree program. That faculty committee determines the degree requirements and the general content areas that are to be examined. Each individual examination is then prepared by a team of faculty who teach that specific discipline on campus. Minimum passing scores are based on administering the test to college students completing that course on their campuses.

More than 60 examinations are currently available, and close to 500 faculty members from private and public colleges in the State of New York have participated in the development of the tests. Also, note that the faculty members who determine the degree and the examination content establish all the academic policies. The faculty review transcripts that are submitted to replace the examination requirement. The faculty grade the examinations, and the faculty vote the degrees and make the recommendations to the Board of Regents.

It is a very active faculty whose names stand behind the degrees that are awarded, who are asked and who agree to go into each region of New York State and discuss in public forum the degree requirements and the way in which these were developed. One of the most gratifying experiences for faculty and students alike resulted from a suggestion made by the faculty: that Regents' External Degree graduates be honored during the regular commencement exercise of colleges in the USNY system. This spring for the second consecutive year external degree graduates participated in graduation ceremonies at 15 New York colleges.

The Regents' External Degree Program is accredited by the Middle States Association. The regents are an accrediting body themselves, but for obvious reasons they sought an outside evaluation, just as we seek an outside evaluation from within our own organization through the Division of Nursing Education. I believe it is the first time that one accrediting body has asked another to review its programs.

The Regents' External Degree Program also operates a credit bank. Simply stated it is the result of taking all the academic policies and procedures established by the regents' degree faculty and applying those to any individual who would like to store his academic record and have it all on one transcript.

This service is desirable for military people and other individuals who move frequently. We did a survey of registrars in New York and found that some 50 percent said they would accept the transcript without asking the individual to get the original transcripts from each of his three or four colleges. Some of our students in the first external degree attended as many as six different colleges. Today one out of every four students on campus changes college at least once before completing a degree.

In addition to evaluating individuals, we have undertaken a project, together with the American Council on

Education, to evaluate programs offered by noncollegiate sponsors. There are more students outside of this formal collegiate structure in the country than inside of it, and many of these students take their courses from institution like IBM, General Electric, Bell Telephone, and other businesses and agencies that, in many cases, offer superior educational programs.

We have begun to assess such instructional programs in New York and will make credit recommendations on the same basis as we make them for college proficiency tests. A college may accept or reject these recommendations.

The New York Regents External Degree: Opportunity for Non-traditional Students in Nursing

By Carrie B. Lenburg, R.N., Ed.D., Coordinator, External Degree Program in Nursing

Because the New York Regents External Degree Program in Nursing is new and markedly different from other nursing preparatory programs, the confusion and misunderstanding about it are not entirely unexpected. The purpose of this presentation is to clarify some of these points of confusion and to respond to your questions about the program. Perhaps this may best be accomplished by discussing three areas of interest: 1) Ways in which the program is consistent with traditional programs: 2) Ways in which it differs, and 3) Some assumptions frequently made about the external degree and other nontraditional programs.

As many of you know, the Regents External Degree Program (REDP) in Nursing was initiated in 1971, and we started enrolling candidates in early 1973. It is fully funded by the Kellogg Foundation but operationally is located in the State Education Department in the office responsible for the several other External Degree programs and the New York College Proficiency Examination Program (CPEP), all under the direction of Dr. Donald Nolan.

Since an article describing the background and early development of this program already has been published,[1] I want to describe the involvement of nursing faculty, the curriculum design and the progress made since the report presented to you last year.

Structure of the External Degree Program in Nursing

Like any other nursing program, this one also operates within a University structure, with levels of administrative hierarchy, including ultimately the Commissioner of Education and the Board of Regents. The name of this institution is The University of the State of New York abreviated USNY, not SUNY, with which it is commonly confused. (See Figure 1.)

The overall structure provides for a coordinator, or director of the nursing program; a nursing faculty, as well as other faculty and resources for virtually all fields of study; a full-time educationally prepared registrar; full-time professional staff prepared in test construction and evaluation, and programs development; as well as essential support and secretarial staff to assist the professionals in the operation of all programs. This totals some 50 people with responsibility divided about one-half for REDP and one-half for CPEP. Much of the work overlaps since both of these programs are part of the same division. The development of Regents' External Degrees grew out of the experience and philosophy of the College Proficiency Examination Program which began in the early 1960s.

In the case of nursing, as with the other external degrees, there is an overall faculty committee composed of nurse educators primarily from New York State. They are responsible for the development of philosophy, objectives, curriculum design, the degree requirements, and other aspects of the program. This nursing faculty, together with the coordinator and members of the administrative staff, developed program recommendations which were submitted to the Board of Regents for their approval; at the appropriate time they also will recommend candidates for the Associate in Applied Science in Nursing degree. The first candidates should be ready for graduation early in 1975.

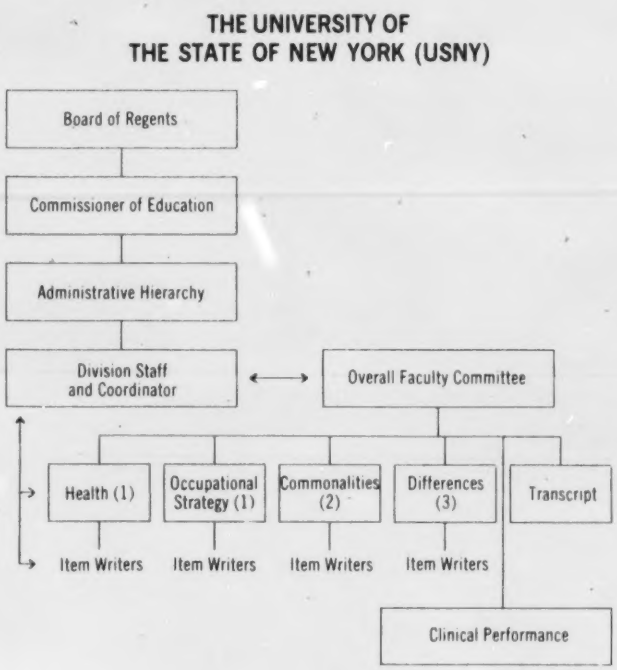

Figure I: Faculty and Administrative Organization

The overall faculty, as with any other nursing program, conducts much of its business through faculty subcommittees. In our case there are six subcommittees, which function somewhat like "departments" in a campus-based program; but in this case each is responsible for an examination content area. These include committees for:

Nursing Health Care (1 exam)
Occupational Strategy (1 exam)
Commonalities in Nursing (2 exams)
Differences in Nursing Care (3 exams)
Clinical Performance
Transcript

Each subcommittee is composed of from one to three members of the overall faculty committee, and four to

[1] Wozniak, Dolores, "External Degrees in Nursing", *American Journal of Nursing*, June 1973, pgs. 1014-1018.

six other nursing educators from existing nursing programs throughout the state. Both public and private institutions are represented; the majority of faculty are from associate degree programs, but practical, diploma, baccalaureate and graduate education also are represented. Each subcommittee constructed a blueprint for each examination, based on the guidelines provided by the overall faculty committee. In response to the blueprint specifications, item writers, who are nurse experts in appropriate nursing content areas, worked with staff and the nursing faculty committee to prepare a pool of some 400-500 usable items for each of the seven cognitive exams. The items then were reviewed by the appropriate subcommittee, and eventually a 150-item examination was prepared for each content area, refined for pilot testing, and ultimately administered to candidates.

The coordinator and psychometrics staff work closely with these committees to produce final examinations and study guides for each area, to revise them as necessary, and to construct additional versions of each examination. The committees are ongoing; their work is not finished even though the first set of exams are complete. The psychometrics staff continue to work with the committees in refining new items to be merged with some of the current items to form new examination versions. This is quite similar to the process used for the construction and revision of State Board exams.

The Transcript Committee and the Clinical Performance Committee function differently. Three from the Overall Nursing Faculty Committee, the registrar, and the nursing coordinator compose the Transcript Committee. Periodically they review transcripts of collegiate nursing courses which candidates submit in lieu of taking the nursing examinations. This Committee makes decisions about waiving any nursing exams.

The Clinical Performance Committee is responsible for developing the final examination in the nursing series. This exam will be described shortly.

Collectively, the faculty of the Regents External Degree Nursing Program probably is the best prepared ADN faculty in the country: 12 have doctorates and 25 have masters degrees. This does not include the administrative staff and item writers, nor does it include the faculty in colleges throughout the state that teach the variety of courses offered in formal settings, which are transferable to this program.

Development and Structure of The Nursing Curriculum

The accompanying chart (Figure II) presents the curriculum design for this ADN program in nursing. Many people ask about the BSN level, and our hope is to begin working on this by next year. The current program leads to an Associate in Applied Science in Nursing degree, which is comparable to the A.S. degree in other states. It requires approximately 30 credits in general arts and sciences, which must be distributed across humanities, social sciences, natural sciences/mathematics and electives, as specified by the degree requirements. However, one of the major attributes of this program is the multiple ways in which these general education requirements may be satisfied. A great deal of flexibility is allowed. For example, a candidate may use any one or combination of the following to satisfy the general education requirements:

a. College transcript from any accredited college or university
b. Proficiency exams, such as NYCPEP, CLEP, CEEB, etc.
c. USAFI
d. Special Assessment

The remaining half of the program is devoted to nursing content. Basically we do not use a credit system as such; rather, candidates are expected to fulfill the degree requirements as specified in the catalog. College credit is *not* attached to the nursing exams.

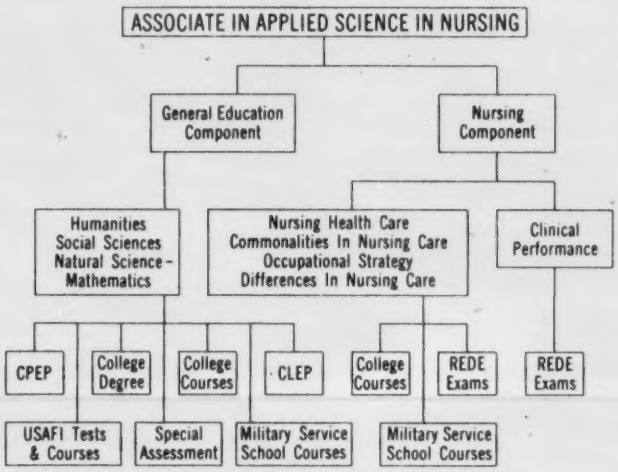

Figure II: Curriculum Organization

The nursing content is integrated throughout the seven cognitive exams. This has been the trend in ADN education from its inception and is coming to be the accepted direction for baccalaureate education as well. Therefore the names of exam areas are different from the customary labels, but the overall content is the same—it has to be—since graduates of this program must pass the same State Boards and practice nursing based on the same body of knowledge as other associate degree RNs.

Norming procedures for the paper and pencil tests established a cut off point of 45 (which is a scaled score) comparable to 31st percentile. In essence this means that 31% of the ADN students who were about to graduate from programs across the state would *not* have passed the Regents External Degree Nursing exams. This represents a passing level of one-half standard deviation below the mean, which is much more stringent than the State Board Licensure exam (one and one-half standard deviations below mean). The faculty committee and psychometrics staff believe such a pass/fail cut off point is more than satisfactory in validating the learning of our candidates.

Candidates must demonstrate sufficient knowledge on all seven cognitive exams before they may apply for the Clinical Performance in Nursing Exam (CPS). In this way patients, as well as candidates, are safeguarded. If the candidate does not possess adequate understanding of basic facts and principles, and cannot apply judgment related to nursing care, he is *not* eligible to go into the patient care setting to demonstrate clinical performance

ability. The CPN exam is still being developed at this time, therefore, final details are not available at this time. The Overall Faculty Committee, which is scheduled to meet in late June, will consider the recommendations and instruments developed by the CPN Subcommittee. The Subcommittee plans to pilot test the performance instruments and process this summer; once refined it will be offered to candidates this fall.

During the last twenty months the CPN Committee composed of 10 nurse educators, has met 18 times, for a total of 34 full days of work directly related to this performance examination. This represents 340 full faculty days devoted exclusively to the development of an objective and meaningful clinical performance assessment instrument. We believe this is noteworthy in and of itself. The faculty believes this examination, along with the seven cognitive exams, is more than sufficient to screen candidates *in*, or *out*, of the nursing program more effectively and efficiently than other evaluation methods currently used by traditional programs. Some tentative points about the CPN exam include the following:

1. It will be administered totally in a general hospital setting.
2. It will require a two-day period.
3. Several Patient Care Situations (PCS) will be assessed. Total care for both children and adults, evaluated one at a time, will be involved.
4. Each candidate will care for one patient while being assessed by one evaluator as the basic unit of the examination. Several PCSs will be provided; the exact number is yet to be determined.
5. The exam covers the entire nursing process, including planning, implementation and evaluation. The candidate must write a CPN according to specifications, and, only after this is approved, is he permitted to progress to the implementation phase. The details are elaborated in the CPN study guide.
6. Probably 2—2½ hours will be required for each PCS. It is a criterion referenced exam, based directly and entirely on the Nursing Process Assessment Guide (NPAG) developed by the nurse faculty CPN subcommittee. Specific areas of nursing care have been defined and *critical elements* identified for each area. The evaluator will observe every aspect of the candidate's performance with the NPAG in hand. Should the candidate fail to meet any of of the critical elements, *that* PCS will be terminated at that point and candidate will be failed. Should the physical and/or emotional well-being of the patient be jeopardized at *any time* during the PCS, the candidate will be interrupted and that PCS will be failed Patients will be protected at all times.
7. At no time will the evaluator leave the candidate during the PCS; it is a 1:1 examination, based on the objective and specific dimensions identified by the CPN Subcommittee. Ordinarily there will be no dialogue between evaluator and candidate; nor will there be showing, or teaching, or correcting. This is a purely *evaluative* procedure.
8. At this time the committee has designated that three PCSs (involving one child and two adults) must be completed 100% correctly, but candidates will have five opportunities to demonstrate this ability. This means that *all* critical elements for each area of care must be properly carried out for three of five PCSs. This is wholly justified since no student—or graduate—is always 100% correct, especially under testing conditions. However, we believe this is much more stringent, objective and effective than in any other program known to us. This may sound too harsh but the faculty believes this is necessary for a non-biased, objective examination which gives equal opportunity for success to each candidate and also protects the patients. These decisions are tentative and subject to change based on the pilot study planned for this summer.

The faculty believe that once the candidate has been affirmatively assessed, in all cognitive and performance areas as well as the general education component, he is eligible for the A.A.S. degree in nursing, and may subsequently take State Board Exams. In developing this program the faculty and staff were just as concerned as other nursing faculty with quality, with patients and with the good of the profession. They truly can be characterized as autonomous, nursing professionals working collectively to develop and implement this innovative non-traditional program to meet the needs of atypical students while at the same time maintaining the integrity of nursing education and nursing practice. They are anything but a rubber stamp committee.

Candidate Characteristics

Some characteristics of our candidates might be enlightening. Based on a recent computer summary of candidates' records, the following demographic factors were analyzed:

1. Age: range 18-70; the average age is 38 years
2. Seventy-two percent are full time and 17% part time employees—primarily in health care facilities
3. Nearly 17% are men (in contrast with about 6% in other AD programs)
4. By background:
   - 8% are RNs
   - 61% are LPNs
   - 10% aides/orderlies
   - 21% other (including medics, nursing students who didn't finish, allied health, and those without any health or nursing background)
5. Nursing candidates from 40 states are enrolled
   - 78% currently enrolled nursing candidates are from New York
   - 22% are from out of state

The number of candidates without some background in nursing is exceedingly small, probably under 4-5%; whether or not they sucessfully meet the requirements remains to be seen. It is important to remember that there are *no* entrance requirements, based on the philosophy of allowing individuals educational opportunity. However, the *exit requirements* are fixed and uphold high standards of academic performance.

Accreditation

After the program was designed and the various faculty subcommittees were in full progress, the staff of the State Education Department reviewed the program for registration. The program received "approval to com-

mence" which is the customary first step for any program in New York.

All of the Regents External Degree programs were reviewed by the Middle States Accreditation Association last fall which resulted in candidacy status, also a first step toward full accreditation.

We have worked closely with the National League for Nursing, and from the beginning Gerald Griffin, Director of the Department of ADN programs at NLN, has attended the overall faculty meetings as an observer. This fall, prior to the time we expect our first graduates, we will apply for NLN accreditation. We already are in the process of preparing for that visit.

Advisory Network

Last fall, as the requests for information from candidates became more frequent, it was decided that a statewide network of advisors would be most helpful. We solicited names from faculties and very shortly had some 50 nurse educators or service personnel who were willing to volunteer their time to assist candidates in their own community. We conducted an intensive one-day workshop for these advisors, orienting them to the entire REDP philosophy and nursing program and to their special responsibilities as advisors.

The advisors function as liaison persons between the central office and the candidates, answering questions, providing information and generally helping candidates figure out their particular course of action in reference to the Regents External Degree Program. They provide monthly reports indicating the nature of their advice with particular candidates. We hope to explore the usefulness of this advisory network and study its effect on candidates and on the program. Advisors have been excited by the opportunity to assist, and we frequently get requests from others who want to be advisors.

Some advisors are nursing service directors who see this type of program as a means of helping them to upgrade their current staff—who see it as a form of continuing education and a way of promoting reliable and capable workers already on their staff.

Most are nurse educators who are able to encourage candidates to seek college courses where this is suitable or to direct them in independent study and review. Whatever the method of study, advisors help the candidates, by phone or in person, to review their past education and experience in reference to the program requirements, and to use whatever learning approaches are most practical and beneficial given the individual circumstances.

Summary of Ways the Program is Different from Traditional Programs

1. The entry and exit requirements are different. There are *no* admission requirements for any of the Regents External Degree Programs; however, very stringent exit requirements must be met to complete the program. We believe this is where the emphasis belongs to insure quality.
2. The philosophy which underlies all of the external degree programs is that *what* a person knows and is able to perform is more essential than how and where he learned it. We have removed the traditional barriers of academic time and space to allow more flexibility in the learning process. A candidate may attend one or several colleges, or may not attend any traditional college per se. Instead he may use independent study, T-V College, autotutorial media approaches, correspondence study, continuing education, inservice education, or other methods. *Most* candidates, however, have had some formal post-secondary education—some have already attained masters or doctoral degrees in another field.
3. Our emphasis is on evaluation or *assessment* rather than on instruction. The external degree nursing program is registered with the State Education Department as an assessment (non-instructional) nursing program. *Learning* takes place, but it takes place elsewhere, depending on the life circumstances of the candidate. But validation of learning to meet the requirements for the degree is done with *great care*, objectivity, and professional expertise.
4. Because we do not provide *instruction*, we do not operate a college in the traditional sense. We do not have resident faculty or students, or classrooms, or courses, or campus. We assess the learning of individual candidates regardless of how, where, or when they acquired the knowledge and abilities. But in order to complete the program, that knowledge and ability essential to the practice of nursing at the AD level is systematically and meticulously evaluated. Equality of learning opportunities, objectivity in evaluation, and flexibility in learning approaches are the major points in this program which deviate from the typical program.
5. Our involvement with students also is quite different. We counsel them by phone, by letter, and through the advisory network. We inform them of the requirements and content of the program, evaluate their knowledge and abilities and ultimately provide the degree to those who qualify.

These are some of the major ways the RED Program in Nursing is different. But as you can clearly see, the similarities are much more extensive. The program operates within a university structure (different to be sure), with faculty and support staff. Great care and concern has been exercised by the nursing faculty developing the curriculum; requirements and evaluation instruments have been developed to measure clearly identified areas of content and abilities consistent with other AD programs.

Research

We already have initiated some aspects of study of the RED program in nursing. We intend to launch a full research project to explore the background of candidates, ways in which they prepare for assessment, and factors which influence their success, or failure in this program, performance on State Boards, and ultimately quality of nursing practice.

Assumptions that Need Exploration

Since programs that emphasize open and flexible learning approaches such as the external degree are relatively new, it is natural that those concerned with the profession raise questions or make certain assump-

tions. But two dangers should be avoided when considering these or any innovation; one is an overwhelming *acceptance* without investigation (the "bandwagon" effect), and second, an overwhelming *rejection* without investigation (traditionalist isolation). Somewhere on the continuum between these two extremes is a position of reason and probity, but this position cannot be found without the willingness and energy required to search out the potential, as well as the problems inherent in the innovation. The search for potential in an innovative program requires a kind of objective detachment from the familiar and trusted routines long enough to mentally explore the new concept. And it also requires the courage to develop, implement and research the deviant path.

Assumptions about innovative approaches such as the external degree have stimulated considerable philosophic conflict within the profession since these assumptions relate to some of the most complex and difficult issues confronting nursing education. These assumptions should become the study questions of both local and national research projects, if the profession is to base its directions on solid evidence.

Instead of relying on assumptions, educators in nursing should rely on the logical, systematic and objective investigation which is necessary to determine the truth of the assumptions. Since nursing is struggling to be recognized as a profession, it seems logical that leaders should follow one of the basic tenets of a profession, and establish relevant goals and practice based on research findings. Some individual schools are doing just that. Those cooperating in the NLN open curriculum project, and others, will be especially helpful in stimulating this kind of investigation. The assumptions summarized below are suggested as topics for study and exploration, for the benefit of nursing practice, and nursing education. They relate both to the Regents External Degree in nursing as well as to other non-traditional programs. Hopefully they will both raise questions and stimulate your efforts toward exploration of new approaches in nursing education.

1. Many assume that standards in non-traditional programs are *lower* and that faculty are *less* concerned with the quality of education. There is a concern that these programs which deviate from the traditional norms are *less* rigorous in their expectations and that nursing and patient care will suffer as a result. Sometimes, there seems to be a direct correlation between the degree of divergence from the norm and the magnitude of these assumptions. In fact, however, there is no evidence that such a general assumption is warranted. On the contrary, it seems more logical to suggest that the level of quality and standards is a function of the administration, faculty, philosophy, objectives and resources, rather than the *approach* used to facilitate educational achievement. For the most part, non-traditional programs must be *more concerned* with quality, since they are much more clearly scrutinized by all concerned.
2. Many assume that non-traditional approaches will *replace* traditional nursing programs. While it would seem generally helpful to increase the openness and flexibility of the learning environment in nursing, the fear that all schools should have non-traditional programs is not based on fact. Many organizations and state legislatures are urging the nursing leadership to be more responsive to the learning needs of nurses, but it is beyond reason for anyone to suggest that all nursing programs should offer only non-traditional patterns. There is evidence of need for both traditional and non-traditional patterns. However, regardless of the type of program, the paramount concern is to encourage more flexibility and to respond affirmatively to the individual needs of the diverse clientele seeking various levels of preparation in nursing.
3. Many assume that non-traditional programs are for the average, typical post-high school beginning student. This is true for some curriculum patterns but *not* true for most non-traditional *career mobility* programs and certainly not true for the Regents External Degree—with an average age of 38 years. The students utilizing such options more often than not are over 21 years of age. They typically represent the adult learner rather than the stereotyped young college student. Frequently they have family and work responsibilities, come with a range of experience, have a different commitment to learning, and a more realistic goal than the younger student. To assume that *all* students, regardless of age, experience, background and commitment, must learn in the same way, would seem to negate several elementary principles of teaching; i.e., begin where the student is, on his level, and capitalize on his past experience to facilitate learning.
4. One of the assumptions made, which is rooted in past traditions and has the most fundamental consequence, is that the responsibility for learning rests with the *teacher* and *institution* rather than with the student. Open and flexible programs such as the RED have turned this notion completely around, insisting that the obligation for learning belongs to the student. The faculty's responsibility is to establish the objectives, to determine how much, and what kind of learning should take place, to suggest methods and resources, to advise and counsel, and to assess the degree of achievement of learning according to the predetermined standards and requirements.

   Probably during the entire history of nursing education—which certainly parallels the rest of education—the focus has been on the teacher and institution rather than on the learning ability, needs and goals of the individual. However, newer approaches and technology are helping to reverse this philosophy. The use of learning contracts, self-paced learning, modules with clearly stated performance objectives, multi-sensory instructional media and valid assessment instruments to evaluate learning provide the tangible support to implement the philosophy.
5. Another assumption that many make is that an *education* can be acquired only when the student is exposed to the classroom and to the *teacher* for a designated number of hours per week, for a specified period of time. On the contrary, many innovative programs have clearly demonstrated that

learning is a function of the individual, and need not necessarily be controlled by time and space. Students who are more mature, more experienced, and more committed, may learn more, in a shorter time, than the post-high school adolescent.

Once again, objective and systematic investigation is needed before one or the other side of the issue can be fully endorsed. There already is some evidence to substantiate that the adult student in career mobility programs in nursing does indeed learn as much, as well, in a shorter period of time.

6. Many assume that nursing ability—both knowledge and skill—cannot be measured through objective instruments; others assume it can be done through evaluation tools of their own construction, but they don't have the time to develop them. Some believe the only way to determine that learning has taken place is to do the teaching themselves.

   New examinations are being developed by NLN; others are available through the New York College Proficiency Examination Program, as well as other agencies. Recently, the Regents External Degree nursing cognitive examinations have been completed, and, through contractual arrangements with legitimate institutions or agencies, both CPE and RED exams now may be made available to those in other states. Furthermore, the Clinical Performance Examination of the regents program will be an invaluable model assessment instrument once it is completed and refined. Other programs are designing clinical performance exams which also may become examples.
7. Another assumption—and one recently made in an article questioning the external degree program—is that individuals—students—cannot change from one perception of role, function and orientation to another without going through an elaborate and structured process, or beginning all over again. The notion of socialization is an important one. Novices must learn their role, their place in the profession and their realtionships with others who have significant adjacent responsibilities. They must learn certain norms and behaviors expected of those in particular levels in the hierarchy.

   The question is *not* about the importance of socialization, but *how it is learned or modified.* There is little or no evidence to support the notion that socialization occurs *only* in a structured and controlled environment, or that the face-to-face contact with *teachers* is required, or that once "learned" it remains ever so. Role models are found all around us in all walks of life and to some extent socialization depends on the composition of our role set, our motivation, and the reference groups we seek. This, too, needs to be researched before the assumption can be accepted or rejected.
8. The last assumption to be considered here is that career mobility programs, such as the external degree, will flood the job market and lessen the quality of nursing care. However, consider for a moment that most career mobility programs, whether those granting advanced placement or an external degree, are for those who *already* have some knowledge and experience in nursing, and who are seeking increased knowledge and better credentials to enhance job and personal opportunities. One might argue just as strongly that the quality of care is expected to be *better* because of the past education and experience of these students, who are more mature adults with a different motivation for learning than young novices. Furthermore, in a very real sense, the external degree program is continuing education, so obviously needed in nursing and all other applied fields of practice. Nonetheless, this assumption, too, should be *investigated.*

There are assumptions. The responsibility of the profession is to identify the issues, to determine some order of priority, and then to set about investigating both sides of the debate. Those of us in the Regents External Degree intend to do just that. Some of the answers will emerge from the NLN Open Curriculum Project (RED is one of those programs included in that project). Other independent and less comprehensive studies now underway also will provide empirical evidence. I suggest that each program which implements an innovative curriculum or teaching approach has some obligation to document its development and results for the benefit of the profession.

As nursing administrators and faculties, state education departments, and state boards of nursing learn more about the work being done by others and realize the care and concern being exercised and the benefits and their success, perhaps they will pave the way for demonstration or study projects in their own state or community.

An attitude of commitment to investigation and experimentation would permit more careful scrutiny of particular approaches before binding decisions are made. After all, that which may be appropriate for one area and one group of students may not be the best for those in other locales. But only research and study will demonstrate this. The hope of nursing education and ultimately of nursing practice lies in the willingness of its leaders to objectively consider new alternatives and to investigate their merits. The increasing number of nurses prepared at the masters and doctoral level also should assist the profession in its goal of improving the quality of preparation and practice for those committed to nursing. The times call for more objective assessment and a less emotional response, which usually precludes the spirit of inquiry. At this point in time, research and demonstration seem more beneficial than debate and assumptions.

In conclusion, I hope some of your questions and concerns have been answered through this presentation. The Regents External Degree Program is being developed very carefully and methodically by nurse educators who are both courageous and cautious. We want, and intend to have, a sound program which will be an asset to those in nursing but one which offers an *alternative*—not a replacement—to the typical *internal* degree programs. We believe that nursing, the recipients of nursing care, and our graduates will benefit from these efforts.

Registration of the External Degree Program in Nursing

By Eileen A. McQuaid, R.N., M.S., Supervisor of Nursing Education, Division of Professional Education

In the State of New York, the State Education Department is the operational arm of the University of the State of New York and of the Board of Regents.

The New York State Board of Nursing is advisory to the Board of Regents in matters of discipline and practice regarding the practitioner, but has never had any responsibility for approval of the nursing education programs.

Staff members in the nursing education unit discussed whether or not they could accept the route of a total assessment model as preparation for nursing practice. This discussion went on for a long period of time and included workshops and conferences to consider the pros and cons, the implications, and what impact these implications would have on nursing education and on nursing practice. Staff finally endorsed the idea as an experiment and, since the New York State education system is an open system, controls could be maintained.

The nursing education unit's criteria are based on statutes governing the education system and interpreted according to the Commissioner of Regulations.

An exception clause important to nursing says that any student in a currently approved nursing program may practice nursing. This is an exception to the state's mandatory nursing practice act.

It was determined that the external degree program had to be an approved program in order for the students to even go through the clinical performance.

The Commissioner of Regulations describes an associate degree and its requirements as follows:

"It shall require two academic years or the equivalent that can be shown to accomplish the same goals."

The external degree program is the equivalent, although there is no time span.

The nursing education unit also has a guide which includes all major content areas in the nursing curriculum. Although the sequence is not defined, other broad support areas are defined.

As the discussion continues, other commission regulations and factors included in the guide will be pointed out.

The approval mechanism for new programs requires showing a need and a demand for the program. Then, the type of resources available must be shown—human resources, faculty, finances, and plant facilities.

After this information was gathered, the program was granted interim registration, or approval to begin, in February, 1973.

Since the interim registration, visits have been made at least once a year, followed by a report to the Associate Commissioner for the Professions. This report contains recommendations concerning observations and problems that have been identified.

Contact was continued by having an observer at all Overall Faculty Committee meetings. The Overall Faculty meets to formulate policy and to determine implementation.

While the interim framework was being developed, meetings with the coordinator and the staff of independent study were held to update information and to discuss plans for test development, security, and for new and revised forms of various tests.

Future plans include continuing current progress visits as the Overall Faculty meets, and as the separate performance subcommittees meet. Prior to the graduation of the first candidates, a full-scale registration visit will be made.

The External Degree Program must also make an application for full registration which is in essence a self-evaluation form covering major topics such as administration and organization, structure of program, policy formulation, and financial support.

Support services such as offices, secretarial help, the registrar's system, administration, the faculty qualifications and the definition of responsibilities, policies for appointment, and admission policies will also be examined.

Also of interest is what happens to candidates who do not make it on the cognitive test—where are they now?

Other items include graduation requirements, records, facilities, and contracts with clinical agencies for the performance examination.

Curriculum will be a feature item, including the philosophy, theoretical framework, objectives in terms of what is to be achieved and how achievement is determined, and the rationale for the organization and the evaluation process.

Also of interest are plans for followup studies on the basis of any quantitative data that is received as a comparison with the State Board Test Pool Examination and also with performance evaluations by future employers.

Site visits will be meetings with administrators, faculty and staff to discuss what has been developed, what needs changing, and, also, test development and security.

A selected sample of candidates and a selected sample of the evaluators will also meet. I would be interested in asking the evaluators, who are instructors in nursing education programs, how comparable the product of this program is to the product of their own program.

Staff in the nursing education unit would meet with the advisors in relation to what they are advising the candidates. Staff should also meet with the contracting agency's personnel to determine what went on in the actual performance examination, and should review any of the materials available. If the performance examination of the candidate was videotaped, staff would review those videotapes and make a comparison of what was determined by the evaluator and the test in relation to the cognitive area. At the end of all this we would file another report with the Associate Commissioner with our recommendations. This report would be used to determine whether or not the program receives full registration.

At full registration the candidates will be eligible to apply for admission to the profession of nursing in New York and gain entrance to the examination for licensure.

The major point I am trying to make is that we recognize this as an experimental project which we are willing to examine. We are still a little hesitant because the project is experimental, and we want to make sure it is moving in the direction that was planned.